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JANUARY · FEBRUARY 1955

children

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

Defiant Youth

The Mentally Retarded

Studying Infant Losses

Educational Television

13c

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VOLUME 2
NUMBER 1
JANUARY–FEBRUARY 1955

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the authors

Readers of CHILDREN need no introduction to Fritz Redl, who writes in this issue on the meanings of defiance. Just a year ago at its first appearance this journal carried an article by Dr. Redl called "Child Study in a New Setting," in which he described the plan and goals of the research study of emotionally disturbed children at the National Institute of Mental Health of the Public Health Service.

In his efforts to help physically and mentally handicapped children and their parents with emotional and practical problems at the Jewish Hospital of Brooklyn, Howard R. Kelman has become convinced of the urgency of better community planning. As a step towards this he outlines herein some goals for the mentally retarded. He was once director of social service at the New Rochelle Child Guidance Center, New Rochelle, N. Y., and at the Kings County Psychiatric Hospital, Brooklyn.

A biostatistician with a doctor's degree in anthropology, Eleanor Hunt has been with the Children's Bureau carrying on quantitative studies on the health needs of mothers and children since 1945. Formerly she was with the Public Health Service where she was engaged in a medical-statistical study of the nutritional status of children and with the Bureau of Home Economics, Department of Agriculture surveying body measurements of children.

Six months before she joined the Joint Committee on Educational Television at its formation in 1951, Blanche Crippen was already working for educational television. Then assistant in radio for the National Education Association, she helped prepare arguments for the FCC hearings on reservation of television channels for educational purposes. Before joining the NEA staff in 1948, Miss Crippen wrote and produced public-service radio programs.

Professor of law at the University of Kansas for the past 5 years, Quintin Johnstone teaches not only law students but also students in social work, whom he offers an introductory law course. In 1954 he was president of the Kansas Family Life Association, an organization affiliated with the National Council on Family Relations.

Victoria Shannon is chairman of the Connecticut chapter of the American Association of Medical Social Workers, which sponsored the discussion she reports in this issue. She herself frequently confronts the task of helping parents face serious defects in their children in her work on the diagnostic team at the New Haven Rheumatic Fever and Cardiac Program to which she has been assigned. She has also been with the Ohio Crippled Children's Services and on the staff of the Vanderbilt Hospital, Nashville, Tenn.

frontispiece

THE OLDEST STORY in the world—the beginning of a new life—never loses its freshness and wonder. But it can be a story of tragedy for mother and child when a defect—blindness, malformation of heart or limbs, brain damage—mar the baby's chances for a normal life.

Such tragedies can in some measure be alleviated by the provision of professional services to mother and child such as those described on pages 10 and 17. But they can only be avoided as research into their causes makes preventive efforts possible.

One menace now being cornered by systematic research is retrolental fibroplasia, the eye disease which brings blindness to so many premature babies. As a result of clinical studies in 18 hospitals which have been participating in a cooperative program sponsored by the Public Health Service, the National Foundation for the Prevention of Blindness and the National Foundation for Eye Research, it is now known that this disease is associated with an oversupply of oxygen given in early care—a factor which can be controlled.

READERS' EXCHANGE

KOTINSKY: Wanted, some "handles"

While Dr. Ruth Kotinsky pleads for more emphasis on interprofessional contributions to knowledge ("An Approach to Interprofessional Understanding," CHILDREN, vol. 1, no. 6) one could wish that she had given more space to describing some "handles" that college and university teachers and practitioners could grasp in taking up the formidable task of increasing the effectiveness of interprofessional teamwork.

It would have been very helpful, for example, if she had made some concrete statements as to what practitioners as individuals and through professional organizations can do to create a climate favorable to interprofessional practice. The graduate and professional schools of our universities are not likely to modify the regimen of training for the doctorate in the direction of interdisciplinary instruction and research until there is clearer evidence that professional practice in the several areas of human behavior can be increasingly carried on by teams of workers from two or more professions.

Within the university framework it is also important to have some specific suggestions for increasing the amount of integrated instruction for undergraduates. The graduate and professional schools of the university cannot base comprehensive graduate programs on the overspecialized undergraduate courses that commonly prevail in the colleges of the country. The dean of the graduate school of one of the big 10 universities recently said to me: "We offer the master's and doctor's degrees in 18 specializations of biology, but the university has great difficulty in securing staff members who are broadly enough educated to be effective undergraduate professors of biology."

The situation he described is also prevalent in the social sciences, the humanities, and the physical sciences.

I should like to encourage Dr. Kotinsky to be quite definite in describing ways and means of improving interprofessional instruction and research at the doctorate level of professional preparation.

Ernest V. Hollis,
Chief of College Administration, Office of Education, U. S. Department of Health, Education, and Welfare

Interdisciplinary research

I should like to make an addendum to Miss Kotinsky's article on "Interprofessional Understanding," in relation to her proposal that advanced doctoral students in schools of social work be stimulated to undertake research projects involving an *interdisciplinary approach* in dealing with problems of human behavior.

If such a proposal is to be productive, it would seem that three things need to be done:

1. The schools of social work need to get together—logically, through the Council of Social Work Education—in order to formulate a series of researchable problems of this type. However, the selection of topics from this formulation should be left entirely with the schools in terms of their faculty-student interest and their particular resources.

2. Each school of social work participating needs to provide itself with a truly interested and willing-to-be-active advisory research committee composed not only of members from departments of the university, but also of specialists from practice outside the university setting. The presence of the specialists will not only add the "something" that is essential if a truly interdisciplinary approach is to be achieved, but should also have a practical value in counteracting possible unwholesome "sibling rivalry" among the university departmental representatives.

3. From the very beginning, provision needs to be made for a systematic reporting of the doctoral studies. The reports need not be costly. At first, some condensation of the dissertations may be necessary. Various organizations such as the American Association of Social Workers, the national welfare organizations, and Federal agencies may need to pool their facilities to assure publication. Without some provision for publication, the research efforts rather than being fruitful will more likely die on the vine.

Norris E. Class,
Professor, School of Social Work, University of Southern California, Los Angeles

It's being done

The "approach" outlined by Dr. Kotinsky is already in operation in the program at the New York School of Social Work, Columbia University. Candidates for the degree of Doctor of Social Welfare are required to show competence in three areas of the social sciences. This is in addition to major concentration in two areas in social work. It is expected that the candidates will have knowledge of the literature, concepts, research methods, and the findings and implications of some of the researches in the respective areas of study in the social sciences.

The curriculum offers the students an opportunity to develop interprofessional understanding through working and studying with social scientists interested in bridging the gap between social science and social work. Classroom discussions and independent work help the students to integrate social-science concepts and knowledge with social-work concepts and knowledge.

In this way, a good beginning is made for cross-fertilization and teamwork. As the doctoral students engage in the formulation and testing of social-work concepts they are very likely to approach the task with a better appreciation of the contribution of the allied professions to the understanding of the nature of human behavior.

Teamwork and cross-fertilization are of vital importance to the service professions as they help to meet the needs of human beings for creative living.

Ira L. Gibbons,
Associate Professor, School of Social Work, Howard University, Washington, D. C.

SCHWARTZ: Confusion in terms

In his article, "Counting Delinquent Children" (CHILDREN, vol. 1, no. 6), Edward Schwartz has effectively outlined some of the problems involved in attempting such a complex task. However, the definition of delinquency as "any juvenile misconduct that might be dealt with under the law" is not much help as long as the laws label juvenile misconduct in such terms as "incorrigible," "ungovernable behavior," "wayward," "runaway," "truant," "refusal to obey parents," and in other vague ways.

Such terms lead to nonuniformity in case classification, for, as a protective device, they are often put on the official court documents in place of specific penal-code violations. Moreover, since practically all children at some time or another, at home or at school, behave in a manner that can be described under such broad headings, to include them in the definition of juvenile delinquency could result in the erroneous conclusion that all children are delinquents. We do not define adult criminality as any misconduct that might be dealt with in courts, including traffic violations or other minor law infractions. If we did we would have practically 100 percent criminality.

Actually in our attempts to measure adult crime, we have omitted most misdemeanor offenses and have confined our efforts to serious or felony crime. This is both logical and necessary—logical because the social group is concerned primarily with serious crime which harms individuals and destroys property, and necessary because it is practically impossible to obtain accurate recording on minor offenders.

While a maladjusted child may be a potential delinquent, maladjustment in itself is not delinquency any more than maladjustment in an adult is criminality. We cannot count children as delinquent on the basis that they may be potential delinquents.

To make real progress towards developing a meaningful system of uniform statistics on delinquency much more work will have to be done on the problem of defining the types of misconduct that are definitely antisocial and are sufficiently deviated from normal child behavior to warrant the community's taking authoritative action in regard to the persons involved. This, admittedly, is a most difficult task, if it can be done at all.

Nevertheless, to count in all children referred to probation departments or juvenile courts for assistance or attention simply cannot provide a satisfactory basis for measuring delinquency.

Ronald H. Beattie,
Chief, Bureau of Chiminal Statistics, California State Department of Justice

As Mr. Beattie suggests, substantial progress in the development of uniform statistics on juvenile delinquency is largely dependent upon the establishment of a useful classification system. However, Mr. Beattie proposes following the pattern used in criminal statistics which is confined to "serious crime which harms individuals and destroys property." The individuals referred to are the persons against whom the crimes are directed.

The juvenile-court movement has been based on the principle that the chief function of the court is to protect children involved in conflict with the law from damaging experiences. The purpose of refraining from charging children with specific felonies is to protect them from the rigors of criminal-law procedures.

To be useful to court and community, classification of juvenile delinquents should be consonant with this principle. If the purpose of the court is remedial and preventive rather than punitive, and if its method is to individualize the child, what is needed is a psychosocial classification of children coming to the attention of community agencies as law violators.

Any good classification makes possible the use of a series of definitions of increasing degrees of specificity. This requires the widest possible reporting coverage in the first instance, which is what is contemplated in our present definitions and procedures.

Edward E. Schwartz,
Chief, Program Analysis Branch, Division of Research, Children's Bureau

What are the methods?

The use of figures of questionable or unknown origin to support the claims of the one-causers, the anti-one-causers, or the excitable but intensely interested one-cure group has increased considerably the ulcer proneness of persons who have been devoting their time and energy to the complexities of delinquency prevention and control. The statistics of the Children's Bureau have been an important instrument in meeting problems created by the intuitive method. Improved validity and reliability of these measures of the national picture will increase their effectiveness as an answer to the more impressionable. They will also furnish a better base for comparing local and State trends and for evaluating the effectiveness of local and State programs.

The sampling procedure described in Mr. Schwartz's article promises to be another great step toward this desired goal.

I wonder if in the near future he may describe in more detail the methods employed in developing the new sample. Would it be well for reporting agencies to record any change of programs or any change of emphasis within their communities which has reflected a change in delinquency numbers? We have found that stepped-up safety drives mean increases in the number of traffic offenders. We know of reorganized departments of local government, anxious to prove their worth, which have recorded all contacts with delinquents instead of only those dealing with the most serious offenders. We know that the inadequacy of other treatment facilities for one minority group within our State has increased greatly the number of delinquents from that group. Do any of these factors occur frequently enough to influence national figures? I think they may. How may we hold these influences to a minimum?

A. Whittier Day,
Director, Youth Conservation Commission, St. Paul, Minn.

FOSTER AND SANDUSKY: ADC a child-welfare program

The problem of providing services to families receiving aid-to-dependent-children grants has become a matter of

(Continued on page 40)

What lies behind defiant behavior? Its meanings must be understood if we are to solve . . .

OUR TROUBLES WITH DEFIANT YOUTH

FRITZ REDL, Ph. D.

Chief, Laboratory for Child Research, National Institute of Mental Health,
National Institutes of Health, Public Health Service, U. S. Department of Health, Education, and Welfare

THE TERM "DELINQUENCY" is used these days generally in vague and confusing ways. Clinically the behavior referred to as "delinquent" may cover a wide range of entirely different afflictions. Sometimes the word is as loosely applied as the popular term "bellyache" which may cover anything from temporary upset after eating too much ice cream to stomach ulcers or acute appendicitis. Nobody in the medical field today would attempt to answer the question "what should be done about it" before finding out concretely just which of the afflictions gave rise to the "bellyache." Unfortunately, however, in the field of human behavior and mental health, the public has not yet reached as wise an acceptance of the variety of ills which may result in excessive aggression or as much respect for the need for specific diagnosis.

The concept of "defiant youth" does *not* coincide with the delinquency problem. Some "defiance" is part and parcel of the normal growth process. It may even be a desirable though an uncomfortable forerunner of a character trait commonly referred to as "integrity" or "spine." Other forms of defiance, however, do overlap with the kind of trouble usually referred to as "delinquency" and constitute a great strain on our communities. On the other hand, not all delinquents show overt defiant behavior. In fact some of the hardest to reach cases exhibit a very "slick" surface conformity an a safe cover for the cultivation of a totally immoral outlook on life or a safe buildup for a long-prepared criminal "splurge."

These facts leave persons concerned with the behavior of today's youth facing two important questions:

1. In what areas are confused public opinion and juvenile delinquency most seriously blocking clinical progress and preventive planning?

2. What types of youthful defiance need to be differentiated in order to begin wise preventive and therapeutic planning?

Areas of Confusion

There are three main areas of confusion:

1. *The Individual and the Symbol*

Most of us have been annoyed at one time or another by the fact that children go through a phase where they suddenly consider us, their parents and teachers, as just a general symbol of "the adult." They seem suddenly to have emptied us of all personal relationships with them. We stop being Mary's dad or Johnny's older friend and represent simply "those adults," the power group from whose grip they are trying to emancipate themselves.

However, we adults don't usually recognize that we begin to do the same thing to our children as soon as they enter the development phases of preadolescence and adolescence. In these periods Daddy does have moments of reacting to his son not so much as a person, but as though he represented the "world of adults" pitched against "youth" which is getting out of hand. Dad's little boy suddenly becomes not his son whom he knows and loves so well, but just an "example" of the way postwar young people act when you don't "keep them in line."

This peculiar phenomenon, natural and harmless within limits, often becomes a real block to wise handling of youthful behavior. It is responsible for much avoidable antagonism between the generations. The more we feel threatened by what youngsters do, the more we fall into this form of stereotyping. As a result many situations grow into sham battles over a "cause," when the immediate problem could have been easily solved if the two adversaries had remained what they were to begin with: two *people* having it out.

2. *Some of My Best Friends Are Teenagers*

There seems to be a tendency in the adult world toward hostility to youth as such which is in striking contrast to the fact that we all "like kids," especially our own or those entrusted to our care. Something seems to happen to the most child-acceptant of us when we suddenly switch from personal involvement with a child to a collective view of the youth problem. This shift in focus tends especially to occur when a youngster becomes involved in some rather atrocious crime—although the act has so obviously grown out of extreme disorganization within the world surrounding him, such a long and involved chain of disturbing events that nobody could logically regard the outcome as "typical" youthful behavior.

A 14-year-old boy tries to defend his mother against the onslaughts of his drunken father and hits him a bit too hard with the piece of pipe he grabs in despair. Why are our newspapers so ready to call this a "teenage crime"? By doing so aren't they implying that this boy is "typical" of the youth of our time, or at least that something about being a "teenager" has brought about the unfortunate event which so obviously stemmed from the pathology of the adults in the boy's life? On the other hand, do the papers write up as a typical teenage deed the heroism of Bobby, an Eagle Scout, who rescued a little girl from drowning? On the contrary Bobby Smith, aged 15, remains Bobby Smith, not a representative of his age, and the heroism is credited to himself. In other words, teenagers are regarded as a breed suspect until proven innocent. Their bad deeds redound on the whole age group. Their good deeds point only to the exceptions that prove the rule.

When public attitudes incline toward stereotyping of this sort there is cause for deep concern. Collective suspicion and negativism of one group toward another always backfire by engendering conscious or unconscious collective counter-aggression and distrust from the other side. To increase intergroup tensions between the "world of grownups" and the "youth of our time" is the last thing we should do at this point in history. Since we have paid such prices in the past for collective prejudices in the areas of race, religion, class, and caste we should know something about the high cost of group psychological pathology.

3. *An Optical Illusion*

Adult disgust with "youth" is easily aroused when the young people gather in mobs. Their boisterous and rather inconsiderate behavior gets on our nerves and reinforces our suspicious stereotypes. Thus, unfortunately, we are taken in by a kind of "optical illusion," for loud and thoughtless behavior is often more typical of the group situation individuals are in than of the individuals themselves. If you doubt this, just remember the last large convention held in your town. Many riotous teenagers would have trouble living up to what otherwise dignified adults can do to hotel-room towels, ashtrays, and doorknobs when they are convening in somebody else's city.

While much remains to be learned about the impact of group psychological excitement on the behavior of the human individual, age, or "teenage", as such is not the main factor involved. The problem of how to predict which person's self-control and value system will melt under a certain amount of group psychological heat and how to help individuals keep sense and control intact under free-floating contagion is one of the most urgent research issues before us. Instead of allowing ourselves to become irritated at an "age range," we should take steps to investigate thoroughly this larger problem of group pathology.

In summary, it seems as important for the fields of mental hygiene and preventive psychiatry to tackle the collective confusions about youthful behavior in which the present adult generation indulges as to cope with the problems of youth itself. We have made wonderful strides with analogous problems in the field of physical medicine and health. Through the astounding successes of public-health education on a variety of levels, present public opinion is enlightened about the nature of invisible germs, accepts even unpleasant facts about the nutritive values of certain foods, and no longer quarrels with the wisdom of certain "first aid" directives even where these contradict deeply ingrained popular myths or personal feelings. But in the field of human behavior the major task of "deconfusing the public" lies ahead.

What About "Defiance"?

Without attempting anything as ambitious as an outline of symptomology and etiology of the "defiant child," we can differentiate a few of the outstanding problems that usually sail under this heading. Here too conceptual confusion, while not the core of the difficulty, is a dangerous roadblock on the way to progress.

1. *Developmental Defiance*

In spite of all the talk about "adjustment," we would not really want children to "adjust" to everything all the time. If they did we would think they lacked "spine." Healthy development on the part of a child is fostered by strengthening not only his ability to adjust to outside demands, but also his ability to defend his own integrity against wrong demands made by others. We want Johnny to be respectful to his teacher but we don't want him to run after the first designing bum that offers him candy just because the man is an adult and looks like a mixture of Abe Lincoln and Santa Claus. On the contrary, we want our children to retain the capacity for *intelligent rebellion*—courage to stick to what they believe in even against strong-armed pressure and the fear of becoming unpopular with the mob.

All traits that we want eventually to see in our children must grow through a range of developmental phases. "Intelligent rebellion," too, needs leeway to be learned and practiced. Of course, while being practiced it often looks anything but intelligent and can be very annoying to the adult who has to live with it. We know from our studies of child development that certain age ranges seem to be especially cut out for the practice of "emancipation acrobatics." The negativism of the child between 3 and 5 as well as the strong "emancipation" efforts of the young adolescent are normal phases in child development. While uncomfortable for educator and parent, these rebellious phases are important as preparation for independence. We also know that defiance which is part of this developmental process is *not habit forming*. It tones down by itself as soon as the character trait of integrity, for the sake of which it was displayed, is sufficiently secured.

Although we have many books that tell us how to cultivate "intelligent rebellion" in the well-adjusted child in relation to the child's dependence on individuals, we have little information on how to help him keep his integrity when confronted with gang and mob pressure. One of the Nation's greatest problems at this time is to find out how to help our young people stick to what they believe in, even in defiance of whatever opinion or action might be popular at the moment with the rest of the youthful crowd. Actually a lot of behavior usually termed "defiance" is exactly the opposite. The 16-year-old who participates in an incident of vandalism because he is afraid of being called a sissy is not a *defiant* child. He is a coward, an overconformist, a spineless lickspittle for public acclaim. The fact that he is overdependent on the wrong opinions does not change the fact that submission rather than defiance is the real problem at hand.

Clinically speaking, then, we have to look a few inches below the surface before we can know what the problems in any specific "defiant act" really are. Where behavior falls into the category of "developmental defiance," it presents us with an educational challenge, but we must not be fooled into regarding it as "delinquency."

2. *Reactive Defiance*

Some youthful defiant behavior may be compared to the process of regurgitation. If you pour poison or stuff pins down somebody's throat, his organism will probably rebel by choking reactions to ward off the hurtful intrusion. Vomiting under such conditions is not symptomatic of illness. On the contrary, it is the defense of a healthy organism against hurt from the outside.

A lot of youthful "defiant" behavior falls into the same category. It is *not* the outcropping of a corrupt or morbid personality, but the defense of a healthy one against the kind of treatment that shouldn't happen to a dog, but often does happen to children. At close inspection even many of the rather frightening and disgusting outbursts of youthful defiance are of this type. In a group of normal schoolchildren bored beyond limit by stupid teaching methods, the intelligent ones will be the first to become "hard to handle." Their misbehavior is a defense against the demoralizing impact of excessive boredom. If a child with deep-seated anxieties is put into solitary confinement under frightening circumstances, the resulting temper tantrum will not be his "warped personality" coming to the fore but his desperate defense against total breakdown into mental disease. His frantic muscle spasms and aggressive mauling of the surrounding outside world are the expression of his inward terror.

Such "reactive defiance" calls for consideration not only of what's wrong with the child but also of what is wrong with what we are doing to him. Every case of really pathological and dangerous defiance which I have had a chance to study closely has had its origin at some time in "reactive" defiance. Many people had to do the wrong things consistently for a long time to the children involved to produce such a severe degree of disturbance. This means that one of our greatest preventive opportunities lies in developing and applying greater knowledge about the most advantageous setting for growing youngsters and in helping adults toward a maximum of wisdom in their reaction to youthful behavior.

3. *Defiance as a Wrapping*

Some defiant behavior is quite clearly "unprovoked," or at least seems so at first sight. Why should Billy, a well-loved and well-cared-for child, one day suddenly act up, hanging on to furniture and kicking and biting when you try to make him go to school? His unwarranted behavior toward you looks dangerously like the "rebellious child" in the making. It looks and feels like that, until you learn that Billy has deep-seated fears of any "crowd" situation—fears that are irrational but extremely intense. The panic aroused in Billy's mind is in itself a "sickness," an anxiety neurosis. This is the affliction, not the "disrespectful disobedience" which he displays when confronted with it.

Other "defiant acts" by youthful offenders may be the secondary accompaniment of any of a variety of mental diseases. I once knew a child who when compulsively hit by sudden intense spurts of fantasy images would get up during class and wander around, impervious to threats of punishment. He *seemed* to do all this "just in order to spite authority." Yet nothing was further from the truth. At these moments, he did not even *perceive* the teacher's presence nor any of the world around him. He had no thought of being "spiteful." It would have been easier to help him if he had, for this child was out of contact with reality far beyond the normal degree of childish daydreaming. This sickness is worse than the usual "defiance." But the important point is that it is *different* and calls for entirely different treatment and preventive measures.

Defiance which comes as a "wrapping" around some other disease is especially frustrating. Because in such cases the techniques so often found helpful in dealing with other defiant children are totally ineffectual, the adult's wrath at the defiant behavior is apt to be increased by his fury at his helplessness. The result is a loud cry for some form of physical punishment. Unfortunately, in these cases physical punishment is the most futile and most damaging technique we could use. Where defiance is a "wrapping" no matter how smell-proof or loose, the only thing to do is to tackle the disease behind the wrapping. All other efforts are useless.

The Defiant Ego

By a "defiant ego" I mean the ego that has thrown itself on the side of the child's impulsivity, defending it against reason and the voice of his "better self" with enormous skill and strength.

This, unfortunately, is the most neglected although the most serious form of defiance. While from the outside it looks very much like other types of defiant behavior, at closer range it reveals itself as a most pernicious and serious affliction which educator and psychiatrist so far are completely helpless to change.

Children with "defiant egos" act destructively any time they so desire because they enjoy it. If they want their "fun" they are going to have it. Either they have not developed that "voice from within" that would make them feel bad about "fun" that is unjustly had at somebody else's expense; or they have developed very skillful tricks of putting that "voice" out of commission should it tend to interfere. Diagnosis, however, is not easy. The size of the offense or the intensity of the defiance gives no clue as to what type of defiance is involved. It is not true that rowdyism marks a child as sickest or worst, while milder or even "cute" forms of rebellion can be passed by as harmless. Nuisance value to others, or intensity and degree of defiance are only a few of the criteria for sizing things up for what they really are.

I know of actions close to murder, which have had little to do with real defiance, but are reactive or psychoneurotic in origin. I also know of cases where as mild a symptom as polite withdrawal from arts and crafts activities—but always exactly when whim dictated and always accompanied by total disinterest and bland imperviousness to the persuasiveness of others—proved to be the forerunner of very severe character disorders which later blossomed into openly recognizable symptom displays.

A detailed description of the "defiant ego" is not possible in the space available. However, this is the type of affliction which may justifiably be classified as "delinquency," even if the defiance displayed does not seem to have any "legal" implications. The early recognition of such afflictions and the determination of conditions for preventive and therapeutic work with them constitute the main themes of the present project at the Psychiatric Children's Unit at the National Institute of Mental Health.[1] [See "Child Study in a New Setting," CHILDREN, vol. 1, no. 1.]

In Summary

The problem of "defiant youth" is complicated by the fact that the adult generation generally lacks conceptual clarity in discussing the issues involved. Furthermore, "defiant" behavior by children seems to bring out the worst in adults, provoking them to react with their own feelings rather than with deliberate thought. The collective "suspicious antagonism" which communities often display against the "teenagers" as a "caste and class" are likely to foster or increase a collective spirit of defiance among youth itself.

The actual phenomenon of "defiance" has many degrees ranging from "light" to "severe and dangerous," from "cute" to "morbidly obnoxious." Unfortunately, the degree does not indicate in any given case what lies behind the behavior. No matter which specific form of behavior defiance may take, it may derive from any one, or a mixture of, at least four types of afflictions. The difference between failure and success depends on whether we gear our curative and preventive measures toward the type of affliction involved.

The answer to the problem of defiant youth must be sought in the direction of more practice-geared research, greater concerted effort toward the education of the public to the causes of defiance, and more courage to think straight even under the impact of panic and wrath.

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[1] Redl, Fritz, Wineman, David: Children Who Hate. Chicago: Free Press, 1951. 253 pp. and Controls From Within. Chicago: Free Press, 1952. 332 pp.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

BORN EQUAL. 10 minutes, sound, black and white, rent.

Interprets the United Nations Declaration of Human Rights, with special emphasis on the rights of children.

Audience: Professional and lay groups and children.

Produced by: Australian Instructional Films.

Distributed by: Library Films, Inc., 25 West 45th Street, New York 19, N. Y.

LET ME SEE. 20 minutes, sound, color, purchase or rent.

Shows parents how they can help a very young child who is visually handicapped. Suggests the potentialities of such children when they receive suitable training and guidance.

Audience: Parent groups.

Produced by: University of Southern California.

Distributed by: University of Southern California, Department of the Cinema, 3518 University Avenue, Los Angeles 7, Calif.

PHYSICAL EDUCATION FOR THE BLIND. 35 minutes, silent, color, purchase or rent.

Shows blind boys and girls taking part in active games and contests, mostly out of doors.

Audience: Those preparing to work with the blind; also parents of children who are blind or partially seeing.

Produced by: Dr. Charles Buell at the California School for the Blind, Berkeley.

Distributed by: Dr. Charles Buell, 2722 Derby Street, Berkeley, Calif.

FOOD FOR FREDDY. 17 minutes, sound, color, purchase or rent.

Points out the essentials of a good lunch for school children and the value of appetizing menus, wise purchasing of food, and proper storage.

Audience: Parents and nutrition classes.

Produced by: National Film Board of Canada.

Distributed by: (sale) National Film Board of Canada, 1270 Avenue of the Americas, New York 20, N. Y.; (rent) International Film Bureau, 57 East Jackson Boulevard, Chicago 4, Ill., and Contemporary Films, Inc., 13 East 37th Street, New York 16, N. Y.

BLASTING CAP. 15 minutes, sound, color, loan.

Explains to boys and girls the dangers hidden in an apparently harmless little blasting cap, or detonator. The film shows three boys finding such a cap. They plan to set it off as they would a firecracker, and tragedy is barely averted.

Audience: School-age children. The film was produced for school safety programs.

Produced by: Frank Donovan Associates, for the Institute of Makers of Explosives.

Distributed by: E. I. DuPont de Nemours & Co., Motion Picture Distribution, Wilmington 98, Del.

These young archers are among the 140 children who have found fun and companionship in a recreation program for the mentally retarded operated by the Detroit Department of Parks. The program stresses group activities.

A PROGRAM FOR MENTALLY RETARDED CHILDREN

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RECENT YEARS have brought slowly changing views of community responsibility toward the mentally handicapped. Earlier attitudes based on a preoccupation with their limitations, ignorance of their capacities for growth and development, and inadequate knowledge of those who lived at home, are stubbornly giving way as more scientific data become available.

While medical treatment of mental retardation is still in its infancy and cannot cure or regenerate damaged neural tissue nor correct faulty neural integration, the functioning of the mentally retarded child is subject to favorable or unfavorable influence and is often amenable to training measures. Moreover, psychological and sociological factors play a significant role in influencing the nature and degree of mental retardation afflicting a million and a half of our children.

In this context we must focus our attention upon the improvement of the condition through habilitative and rehabilitative measures.

The fundamental needs of mentally retarded children are the same as those of other children. Briefly, the requisites are: a stable, financially secure, and accepting family group; appropriate school and recreational facilities; and preparation and training for productive work. Naturally, the material necessities such as proper diet, housing, and medical care are as important to these children as to all others.

For the child with special problems or afflicted with a special handicap access to these necessities is so difficult that special provisions must be made.

Many mentally retarded children can become valuable assets in their homes and in the community if they are given the proper help and training. This involves not only early detection and diagnosis, but also appropriate school placement, suitable home management, speech therapy and remedial reading, and stimulating social experiences. As the child grows into adolescence, vocational education and guidance, job training and placement, appropriate social outlets, and suitable living arrangements become important.

Rehabilitation or more correctly the habilitation of the retarded child is a many-sided undertaking cutting across the responsibilities of many disciplines: medicine, education, psychology, and social work. The cost and the necessary array of facilities

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This article is adapted from a paper presented at the 1954 Forum of the National Conference of Social Work.

involved in a total rehabilitation program put it beyond the means of the vast majority of families of retarded children. Therefore the community has a responsibility to consider the varying degrees of handicap in making existing services available for such children as well as establishing the additional services that may be required. Only then can the 75 percent of the retarded group who, according to Surgeon General Leonard A. Scheele, are capable of being rehabilitated [1] become productive, contributing members of the community.

The Families

The families of mentally retarded children deserve special consideration. The maintenance of healthy family relationships is not an easy job for any family these days, even those where handicapped children are not present. But the additional strains and stresses placed upon the family of a retarded child can lead to many serious personal disruptions and contribute to family disorganization.

To each parent the experience of having a retarded child has an individual meaning and often a staggering impact. Moreover, the mother and father's ability to manage their child is subject to the influence not only of their own personality structures and the nature of the child's handicap, but also of the attitude of society. If the child and family are held up to public ridicule and scorn and approached with fear and suspicion, the parents' feelings of shame, guilt, and anxiety will be aggravated.

Anxious and overwrought by their child's condition, many parents of retarded children have also had to bear the callous rebuffs of professional persons who may have falsely reassured them that "Billy will outgrow his slowness—don't worry so much," or the nonprofessional advice of "friends" to "put him away now before you get too attached to him" for "Billy will never amount to anything."

The slow-developing toddler not only saps his mother's physical and mental health but often because of his complicating health problems drains the family pocketbook. Waiting patiently for Billy to outgrow his condition parents become painfully disillusioned as his differences from normal youngsters become more strikingly apparent with the passing years. Withdrawing Billy from contacts with strangers to protect him from hurt does little to ease his problems and creates many more for his parents. Often the accompanying overprotection retards Billy's functioning further.

Family tensions mount as disagreements between Billy's parents about how to deal with him increase in frequency and intensity. Tense and overwrought they may come to regard him as *the* cause of their misery.

Kanner,[2] Sheimo,[3] and others have written in detail about the complications of the parents' anxieties and perplexities. Siblings of the retarded child also become involved in these difficulties.

Family-service agencies can make a distinctive contribution to the maintenance of healthier family life by offering counseling, financial aid, homemaker, and other services to parents of retarded children. However, for too long they have, with a few notable exceptions, kept their doors closed to these harassed people. Only recently have they more generally begun to take an interest.

Special Clinics

Closely tied in with the need for family counseling is the need for special diagnostic and treatment clinics. Most parents have found it impossible to get the diagnostic and prognostic help necessary to proper planning for their child's care. Child-guidance clinics have tended to confine their services to children with problems not involving mental deficit. Most clinics dealing with mentally retarded children do so solely in connection with institutional commitment.

Special clinics for retarded children staffed by personnel from several interested disciplines can be of immeasurable assistance to the parent and to the community in providing basic diagnostic and treatment services, and in initiating the type of rehabilitative services essential to the child's well-being.

Such clinics are also useful for training personnel as well as for research and investigation into the lesser known aspects of mental retardation. Dr. Joseph Wortis in reviewing the experiences of the Morris J. Solomon Clinic for the Rehabilitation of Retarded Children in the Jewish Hospital of Brooklyn has pointed to the promise in this work.[4]

Once you get accustomed to the slower pace of the retarded child, you find that these children have the same variety of charming, affectionate, and happy, or morose, difficult, and neurotic or psychotic traits that are encountered in work with other children, although the incidence of more disturbed children is unfortunately greater among them, partly because of faulty neural integration, but mostly because of the many frustrations these children experience. These children grow and develop, learn new things, and in a great many cases, with proper help and training, are capable of growing into happy and useful adults.

Since variations in the severity of mental handicap come about as a result of the complex interaction and timing of biological and environmental influences, the determination of the degree of mental handicap is a complex problem and cannot be quantified adequately on the basis of a mere test score. It must include a careful estimate of the medical aspects of the condition; a thorough estimate of the whole of the child's social experience; his family life, schooling (or lack of it), and social contacts, and must weigh the effects of other complicating factors such as speech disabilities or sensory and motor defects.

The goals of treatment should be individual and realistic. Some will require short-term and some long-term planning. Such goals should be based upon a careful evaluation of the child's handicap as well as his assets and capacities.

In one case the plan may be to improve the child's self-care skills—feeding, washing, toileting, dressing—through a combination of occupational therapy for the child and social casework for the parent. In another case the goal may be to prepare a child for special-class placement through weekly group-play therapy sessions. Or a parent may request help with concrete home-management problems. Another child might require medication to control his convulsions while a remedial tutor helps him to increase his meager reading abilities. Many children require speech therapy. Many parents require guidance. Still other children need a chance to develop socially in a well-structured group setting. In all cases the aim should be practical, should involve the parents in planning, and should attempt to use any community resources that might be helpful.

School Services

School services for retarded children have been in existence both in institutions and in the community since the early 1900's. Special classes have been geared to those retardates considered "educable"—children functioning in the borderline to moderately retarded range. Generally, the criteria for admission to public-school special classes exclude children under 7 years of age or with IQ's under 50, but even so there are insufficient classes to meet the needs of the "qualified." It has been estimated that not more than 20 percent of all retarded children of school age were enrolled in special classes for the school year 1952–53.[5]

However, enrollment of mentally retarded children in special schools and classes in public-school systems in this country increased by 30.5 percent in the 5 years between the school years 1947–48 and 1952–53. This growth is more than 1½ times as great as the increase in general public-school enrollment.[6]

The schools are placing increasing emphasis on services to children with IQ's below 50. In 1952–53 this group represented about 4 percent of the retarded who were given special educational service in the public schools.[6]

Until very recently almost no provisions had been made for severely retarded but "trainable" children. Now, however, a few States, including California and Ohio, and some local communities have set up programs, some in cooperation with parent groups. In other States the parents' groups themselves have organized such classes. A survey of these programs and of the educational problems of the severely retarded child, made by the U. S. Office of Education, has indicated that many children in the lower ranges of mental development can benefit greatly from an educational or training program suited to their needs and appropriate to the degree of their handicap.[7] The survey has shown too that the determination of who can benefit from classes cannot be based solely on a test score but must include an evaluation of the child's medical condition, his potential for social adjustment, his capacities for learning self-care, and other factors.

For the preschool-age retarded child the chances of obtaining nursery school or day-care services are very poor. The child is usually socially isolated and often rejected by his peers.

Only in a few scattered instances has any attempt been made to provide such care through a community service. At the Morris J. Solomon Clinic a program quite similar to that offered in day-care centers and nursery schools is operating on an experimental basis. We have also been successful in placing several youngsters in private nursery schools and have been delighted, as have parents and often the surprised school personnel, at the progress these children have made. Many severely retarded youngsters cannot be integrated into a normal nursery-school program but can benefit from a training program more appropriate to their needs.

Group Experience

Along with the inadequacy of school services for retarded children is a dearth of facilities available to them for recreational and group experience. The need for such experience is most acute for children and adolescents who are not attending school. Leading relatively sedentary, isolated lives, these children are ill-prepared to mingle socially or to face alone the trying demands of adolescence.

Many borderline and mildly retarded youngsters could be successfully integrated into the services for recreational and group experiences now in existence, with little modification of program. Since social skills represent the greatest growth potential for most retarded children, to deny them help in this area means crippling their chances for successful social integration and prolonging their dependence on others. Some national organizations, including both the Boy Scouts and the Girl Scouts, have already demonstrated in some areas the possibility of adjusting eligibility to admit retarded children to membership. If community centers could also see their way to welcoming retarded children, enormous benefit would result.

Residential Treatment

Consideration must also be given to needs of those mentally retarded children living in institutions. While some require institutional care, all too frequently the necessity for placement has arisen from: the lack of other community facilities and special services; the attitude of professional persons who regard institutionalization as the *only* way to deal with the problems of the more obviously retarded child; family problems involving tensions and disruptions or economic and social considerations.[8] Too seldom is the child's actual condition the determining element in the placement decision.

The reluctance of most parents to place their child in an institution, even when such care seems best, is aggravated by the very real inadequacies of many institutions—overcrowding, sparse training facilities, staff shortages.

The institutional crisis continues to grow. In 1948 the 92 State institutions reported a resident population 14.4 percent above capacity, an increase in overcrowdedness from the year before.[9] The institutional problem is further aggravated by the expanding life span of institutionalized retardates, and the many new demands for placement coming at earlier ages than formerly.

Such overcrowding makes it impossible for State schools to offer much more than custodial care and forces them to neglect educational and training programs.[10] Parents whose children need placement face the intolerable dilemma of long waiting lists or of plunging themselves deeply into debt to pay for private care.

The expansion of community facilities would no doubt decrease some of the pressures now facing State schools, and would enhance their ability to improve their treatment, education, and rehabilitation programs. New Jersey, for instance, has found it possible to eliminate some children from its institutional waiting list through a program of training parents to help their children at home.

Other Needs

Camping facilities for the retarded are virtually nonexistent, as are foster homes and temporary shelters. A critical need also exists for guidance and counseling for the retardates themselves, especially the adolescents. Vocational guidance and job training opportunities are usually closed to them.

However, even if our communities should provide a well-rounded and integrated program of services for mentally retarded children, as these children grow into adolescence and adulthood, they are unlikely to find their productive capacities put to use, unless more sheltered workshops or industrial cooperatives are available in which they can produce under noncompetitive conditions. Our society has become so specialized and so highly competitive that the handicapped person's needs are not accorded recognition. It is highly unlikely that the efforts of voluntary agencies alone can fill this void.

Prompted by social rejection and humiliation, and the desire to secure more humane treatment for their children, parents of retarded children have in recent years banded together to help themselves. In self-help groups many of them have been able to overcome a sense of isolation and, thus strengthened, to initiate

Learning to button and to tie. Many children who have never been able to master the skills required in dressing and undressing can do so when they receive help and patient attention from teachers in specialized classes.

some of the services for their children that they have been long searching for in the community—special clinics, school groups, and recreational clubs. Their forceful espousal of their children's needs has also served to reawaken the interest of professional persons and others in the community.

Organization of the parents of mentally-retarded children is a comparatively recent development paralleling similar developments in other areas of need and sparse services, such as cerebral palsy, epilepsy, and muscular dystrophy. In the space of a few short years these local self-help groups have grown rapidly. In 1950 they joined together to form the National Association for Retarded Children whose membership spans the country, numbering many thousands.

Much of the good work of these parents' groups needs to be brought to the attention of the community as a whole and specifically to the taxpayer, the legislator, and professional persons, including workers in community planning and in health and welfare agencies. Unfortunately some professional persons have hesitated to work with these groups because of what they regard as boisterousness, lack of sophistication about community planning and fund raising, and "emotional involvement" in the problem.

While these views may have some factual basis, parents' groups represent a social phenomenon whose existence cannot be denied and whose influence is growing. As their long pent-up energies and boundless enthusiasm are channelized in constructive and creative fashion these organized parents are doing much to inject into the field of community health and welfare services a new spirit of hopefulness, of creativity, and of closeness to the recipient of services.

Steps Ahead

The problems of the mentally retarded child must be faced and solved as competently as possible, not only for humanitarian reasons, but for the very practical benefit of society as a whole.

We are paying for our neglect of these children not only by having to maintain and to support large and costly institutions for their permanent care, but also through loss to the community of their potential social contribution. Following are some suggestions of measures that might help to alleviate current chaotic conditions:

1. Reevaluation of intake policies of voluntary and public health and welfare agencies with a view toward serving the retarded child as well as his family.
2. Application of the skills of group work and recreational agencies to groups of retardates and the inclusion of the mildly retarded in the already existing programs and centers.
3. Extension and improvement of school services for "educable and trainable" retarded children through support from public as well as private community sources.
4. Establishment by communities of special diagnostic and treatment clinics for retarded children where comparable facilities are unavailable.
5. Broadening of Federal and State programs serving the physically handicapped to include the mentally handicapped.
6. Voluntary and tax-supported subsidization of job training centers and sheltered workshops.
7. The granting of earmarked funds for research in preventative, treatment, and rehabilitation techniques.
8. Establishment of curricula in professional schools to offer courses of study in work with the retarded.

In all of these endeavors professional persons can look to the parents of mentally retarded children for encouragement and support.

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[1] Scheele, Leonard A.: Quoted by Gerald Aster in "Out of the Shadows' Look," February 10, 1953.

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[3] Sheimo, S. L.: Problems in Helping Parents of Mentally Defective and Handicapped Children. American Journal of Mental Deficiency. 56: 42–47, July 1951.

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[5] College and University Programs for the Preparation of Teachers of Exceptional Children. Department of Health, Education, and Welfare, Office of Education, Washington. Bull. 1954, No. 13. (In press.)

[6] The Biennial Survey of Education, 1952–54, Chapter 5—Statistics of Special Education for Exceptional Children, 1952–53. Office of Education.

[7] Hill, Arthur S.: The Forward Look; the Severely Retarded Child Goes to School. Bulletin 1952, No. 11. Office of Education.

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[9] Patients in Public Institutions for Mental Defectives and Epileptics: 1948. Mental Health Statistics Current Reports. Federal Security Agency, Public Health Service, National Institute of Mental Health. December 1950.

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Deaths at or near birth are still too frequent. That's why so many States are . . .

GETTING AT THE FACTS OF INFANT LOSSES

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Assistant Chief, Program Analysis Branch, Division of Research, Children's Bureau

MORTALITY associated with having a baby or being born in the United States has declined. However, in 1951, fatalities to mothers and to infants before, during, and just after birth were estimated at 165,000 or about 10 percent of the total mortality in the United States. Such deaths were exceeded only by deaths from heart disease and from cancer.

Many contributing factors have reinforced one another over the years to accomplish the gains so far made toward greater safety in childbearing and in being born. Progress in medical science, its wider availability, and growth in public health measures, as well as in economic well-being, have played important roles. Fact-finding in the form of epidemiological and clinical research has been a powerful and indispensable tool in delineating the problems, in identification of "causal" factors, and in evaluation of alternative solutions.

The maternal death rate in 1951 (7.5 per 10,000 live births) was about one-eighth its size in 1915.[1] Infant mortality in the first year of life was reduced in the same period almost 75 percent from nearly 100 per 1,000 live births to 28.4. Since the early 1920's the recorded ratio of infants who died before and during birth (fetal deaths) to live births has dropped about 43 percent.[2]

Factfinding activities in a number of States give hope for even further reduction in these losses.

Maternal Mortality

While maternal deaths numbered 2,812 in the United States in 1951, State and local medical committees on maternal mortality through their recent investigations of individual maternal deaths have found that even today many maternal deaths can be prevented, through earlier and better cooperation on the part of the mother, or greater availability of services, or improvements in care.

Reduction in maternal mortality among nonwhite mothers lags nearly a decade behind the downward trend among white mothers. The rate for nonwhite in 1951 was 20.1 per 10,000 live births, about the same as the rate for white mothers in 1943.

Outside of metropolitan counties, risks in childbearing are about 84 percent higher than those for mothers living in metropolitan counties. There are also wide variations among the States. In 1950–51 State maternal mortality rates varied tenfold, from a low of 2.3 in North Dakota to 22.7 per 10,000 live births in Mississippi.

According to recent reports of studies in conjunction with State programs of maternal and child-health services at least 36 States had medical mater-

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Parts of this article were prepared on the basis of special materials furnished by the following: Helen W. Bellhouse, M. D., Director, Division of Maternal and Child Health, State Department of Public Health, Georgia; Edward Davens, M. D., Chief, Bureau of Preventive Medicine, State Department of Health, Maryland; A. H. Elliot, M. D., Director, Personal Health Division, State Board of Health, North Carolina; Helen B. Fraser, M. D., Director, Division of Disease Control, State Department of Health, West Virginia; Alfred Yankauer, M. D., Director, Bureau of Maternal and Child Health, State Department of Health, New York.

nal-welfare committees or other study groups investigating individual maternal deaths.

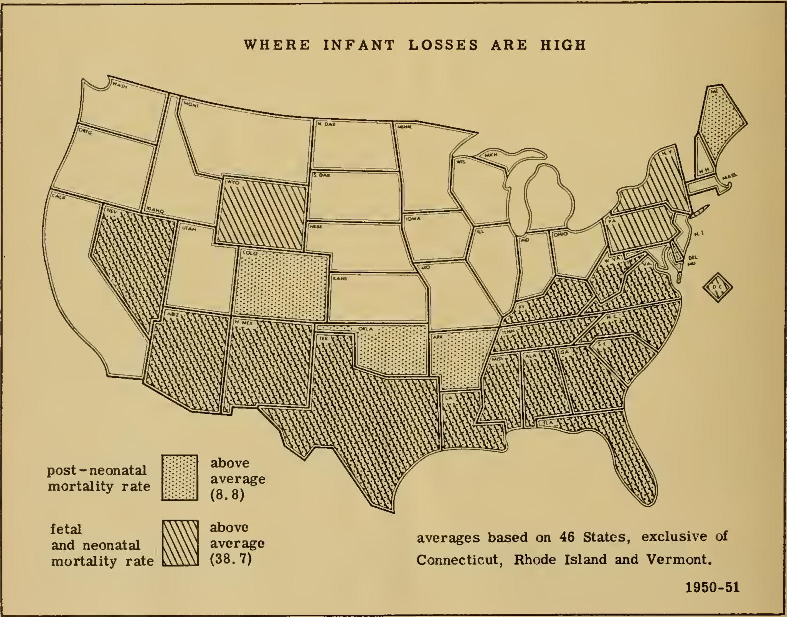
Infant Losses

Numerically the problem of early infant losses is far greater than the problem of maternal mortality. In 1951, according to the estimates, some 162,000 infants died in the United States, before, during, or soon after birth. Neonatal deaths (deaths under 28 days after birth) accounted for 75,192 of these losses.[3] In addition to these, about 87,000 infants whose mothers reached 20 weeks or more of pregnancy died prior to or during birth, 70,569 of these deaths being officially recorded.[4] These intermediate or late fetal deaths are exclusive of early fetal deaths, occurring prior to 20 weeks of pregnancy. Throughout this article the term "fetal death" refers only to deaths of infants in pregnancies of at least 20 weeks duration. These figures indicate that nearly 4 percent of the mothers whose pregnancies reach 20 weeks or more give birth to a dead child or a child who dies in the first month of life.

More than two-thirds of all of the deaths in the first year of life occur in the neonatal period, and over one-third on the first day of life. Nearly two-thirds of these neonatal deaths occur in premature babies, or infants weighing 2,500 grams or less at birth.[5]

Fetal death rates and neonatal rates have declined much more slowly than has the post-neonatal mortality rate—deaths of infants after the neonatal period per 1,000 surviving this period. Between 1945 and 1951 the post-neonatal death rate in the United States dropped 41 percent. In the same period the fetal mortality rate—fetal deaths per 1,000 total births—decreased only 21 percent. Neonatal mor-

Figure 1.


WHERE INFANT LOSSES ARE HIGH
WASH
OREG
CALIF
NEV
IDAHO
MONT
WYO
UTAH
COLO
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N MEX
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S DAK
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OKLA
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MINN
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MO
ARK
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WIS
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MASS
N J
DEL
MD
D C
post-neonatal mortality rate ░ above average (8.8)
fetal and neonatal mortality rate ▨ above average (38.7)

averages based on 46 States, exclusive of Connecticut, Rhode Island and Vermont.

1950-51

tality declined even less, 18 percent. The mortality rate for the first week of life was reduced by only about 11 percent. The joint fetal and neonatal mortality rate (fetal deaths plus neonatal deaths per 1,000 total births) dropped less than one-fifth, while the post-neonatal mortality rate was cut by more than two-fifths.

To some extent high fetal and neonatal mortality in the United States is a regional problem which follows a distribution similar to the post-neonatal mortality distribution. The map in figure 1 presents data for 1950–1951 bearing upon this relationship, although it cannot be accepted as a wholly accurate portrayal because of State differences in completeness and coverage of reporting, particularly of fetal deaths. Three States, Connecticut, Rhode Island, and Vermont, are not included because they do not record fetal deaths in pregnancies of certain durations recorded by the other States. As the map shows, the broad areas of high fetal and neonatal and post-neonatal mortality lie largely in the southern sections of the United States. Above-average joint fetal and neonatal mortality in New York and Pennsylvania probably reflects more complete reporting of fetal deaths. In the District of Columbia and Wyoming, high joint rates are partly explained by above-average neonatal rates.

Fetal and neonatal losses among nonwhite infants in the United States are notably higher than among white infants (fig. 2). The joint fetal and neonatal mortality rate for nonwhite infants, in the 30 States having 5 percent or more nonwhite births, was 61 percent higher than the rate for white infants. The fetal death rate alone, for the nonwhite group (fetal deaths per 1,000 total births to nonwhite mothers) was 85 percent higher than the rate for white infants. The neonatal rate for the nonwhite infants exceeded the rate for white infants by 42 percent.

Some of the excess of fetal and neonatal loss in the nonwhite group reflects the fact that nonwhite mothers begin bearing children at an earlier age than white mothers. During their reproductive years, nonwhite mothers also bear a larger number of children. However, the difference between nonwhite and white groups in joint fetal and neonatal loss is greater than can be explained on these bases alone.

Obviously the immediate hope for further substantial gains in conservation of infant life lies in greater control over mortality of infants before, during, and soon after birth. Therefore, it is encouraging to note that in an increasing number of States studies are under way to learn more facts about the circumstances surrounding such deaths.

Investigations of neonatal mortality were brought into sharper focus in a number of States and localities when means were devised for comparable study of the problem in premature infants. These involve matching birth certificates carrying a notation of birth weight against neonatal death records. The procedures are outlined in the publication, "Recommendations for Developing Comparable Statistics on Prematurely Born Infants and Neonatal Mortality," issued in 1950 to health agencies and others by the Public Health Conference on Records and Statistics, the Association of Maternal and Child Health and Crippled Children's Directors, the National Office of Vital Statistics, and the Children's Bureau; and in "Suggested Tabulations of Statistics on Birth Weight and Related Characteristics for Live Births and Neonatal Deaths" subsequently made available by the same agencies.

About 20 States and localities have compiled neonatal mortality data for infants in different birth weight groups by using this method. From these data, State and local health departments, the medical profession, and hospitals can find out not only the incidence of prematurity in their States, localities, or individual hospitals but also the survival rates for prematurely born infants at different birth weights. Such information is necessary to help in assaying needs of premature infants and the general effectiveness of services available for them. These, and more detailed data on cause and age at death, help to localize specific problem areas for more intensive study.

Various other types of studies are also under way. It seems appropriate to describe a few of these studies to show some of the different methods of attack, though space limitations do not allow for anything like a complete inventory of everything now going on in this direction. The reader interested in a comprehensive listing is referred to the bulletins of the Children's Bureau Clearinghouse on Research in Child Life. The studies noted in the following paragraphs are examples of those conducted by or in cooperation with State or local maternal and child-health programs as described in State health department plans or in supplementary materials.

Studies of Prematurity

To evaluate current premature programs, the Maryland State Department of Health and the Johns Hopkins University School of Hygiene and Public

Health have been carrying out a field study of the 4,700 premature infants born in Maryland during 1952. The study's first aim has been to learn the effects of different kinds of hospital care upon survival. A more far-reaching purpose is to obtain information about infants who do survive in order to determine how many of them develop normally and how many are handicapped by such conditions as mental retardation and cerebral palsy. This information will be compared to similar information on a group of matched controls of full-term infants.

The data from this study will be useful in the formulation and modification of standards for newborn nurseries. The ranking of hospitals according to their degree of fulfillment of present standards and the observed relation of hospital rank to survival of premature infants will furnish an index of validity of present ideas on what constitutes good quality of care. Precise information will be available on specific practices of hospitals and the extent to which they deviate from present standards. The study process itself has already had a beneficial effect on the standards of some of the hospitals.

Preliminary findings suggest that the results of the study will indicate the desirability of recognizing prevention of prematurity as an essential part of a premature program and will call attention to the need for improved methods of maternity care for all expectant mothers, particularly those in the less favored socio-economic groups.

The factual data are also of use to the State medical society and the health department in working with Blue Cross Hospital Insurance authorities with regard to insurance coverage of hospital care costs for premature infants.

In the District of Columbia,[6] in Baltimore,[7] and in Colorado[8] special studies have explored other phases of the problem of prematurity.

In the District of Columbia study, the questions were pursued as part of a larger inquiry into the completeness and accuracy of official birth and death records and their uses to improve standards of maternity and newborn care. The study showed the incidence of prematurity among Negro mothers in the District of Columbia to be lowest among those who received early prenatal care, higher for those whose care started in the second and third trimesters of pregnancy and highest for those who received no prenatal care. Since 3 out of 4 Negro mothers who received no prenatal care were delivered at the city hospital, these findings bore directly on availability of prenatal care in the community for those dependent on public care.

This study showed a significantly higher incidence of premature delivery among unmarried mothers than among other mothers. It also showed a much higher incidence of prematurity among mothers who experienced some complication during pregnancy than among others.

In the Baltimore study, birth weights of single-born infants of white mothers were viewed against the mothers' socio-economic status. This was judged on the basis of median rental, 1950, in the census tract of residence. The frequency of premature birth (adjusted for differences in age and parity among the mothers) was found to vary inversely with the index of socioeconomic status, being 7.3 percent in the lowest socioeconomic tenth of the city, and 5.1 in the highest tenth. However, these differences were smaller than the total difference in incidence between white and nonwhite mothers. In addition to contributing to a wider understanding of the phenomenon of prematurity such facts are useful in planning for provision of prenatal care and services for prematures.

Other Neonatal Studies

Another development which has helped to make the attack on neonatal mortality a great deal more effective is the systematic study of pathological and clinical findings on neonatal deaths in combination with inspections of maternity services in hospitals. In Chicago, long term and continuing studies of this character are major components in the overall Chicago program to reduce infant mortality.[9]

The Study of Neonatal Mortality in New York City—cosponsored by the New York Academy of Medicine and the Health Council of Greater New York—illustrates a slightly different approach and emphasis. The first section of this study is a comprehensive survey of hospital facilities for infant and maternal care.[10] A parallel inquiry is the clinical investigation of neonatal deaths.

New York State has under way, and will expand, statistical analyses of data on the official birth and death records as an integral part of a program to improve hospital maternal and newborn care. Statistics relating to mortality of infants of different birth weight and to incidence of operative procedures in delivery are available for each hospital in the State and will be utilized in connection with the annual inspection of hospitals.

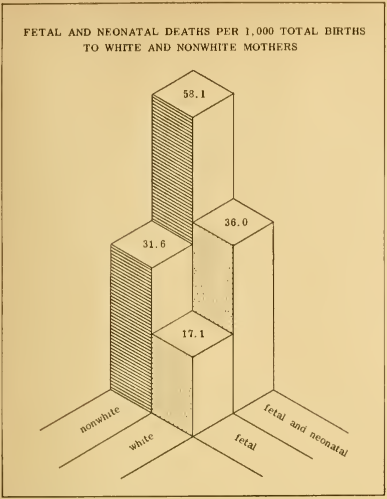

Figure 2.

Vital-statistics data will again be used to evaluate the premature infant care program, being developed in a statewide network of hospitals approved for such care on the basis of set minimum standards. These data will make it possible to observe differences, if any, in infant morbidity and survival, between these hospitals and others.

Vital-statistics data will be supplied by the State health department to State and county medical societies to assist them in their review of hospital obstetric procedures and mortality statistics. The medical groups will investigate the reasons for any unusual incidence of operative procedures, or for an excessive fetal or neonatal death rate, and will seek to improve current practices in those hospitals where rates are high.

To serve these purposes effectively, accuracy of the information on the vital records is indispensable. Therefore, in an effort to find ways of increasing the validity of reported medical and health information the State conducted a study on the accuracy of the data recorded on the birth certificates by comparing a large sample with the data on the hospital records, and is now gathering information on individual hospitals' methods of preparing the birth certificate, for correlation with the findings on accuracy.

In West Virginia, groundwork has been laid for a study by the State health department on neonatal and infant mortality in one county. This study, to be based on vital records as well as a survey of county resources, is to serve as a pattern for similar surveys in other counties as well as to furnish facts needed by local physicians and public-health workers in joint planning of remedial measures. Analyses of official records on neonatal mortality in hospitals of the area will be used in consultation directed toward improvement in standards of maternity and newborn care. Recently, the results of an investigation of incidence of prematurity, and maternal, infant, and fetal mortality in each county of the State were made available to interested physicians and public-health workers throughout the State.

Studies of Fetal Losses

Several States are breaking new ground through studies focusing on the influence of maternal factors in fetal as well as neonatal loss. These studies are variously described as concerning causes of fetal death (Oregon, Virginia); pregnancy wastage (Pennsylvania); maternal aspects of prematurity and fetal wastage (New Jersey, Maine); maternal, fetal, and infant losses (Georgia); bearing of maternal factors on condition of the offspring (New York); fetal and neonatal wastage studies (North Carolina); and longitudinal studies of pregnancy (Hawaii).

In Georgia, the State health department, functioning in the role of physician to the community, has asked the maternal and infant welfare committee of the State medical association, initially concerned only with the problem of maternal deaths, to study the problem of fetal and neonatal deaths. The committee is composed of three obstetricians, three general practitioners, two pediatricians and the director of the department's maternal and child health division. A subcommittee group representing each medical organizational district has been appointed to assist in correlating information and action at the local level.

The maternal and infant-welfare committee uses a "friendly questionnaire" process to collect information about maternal deaths from physicians. The questionnaire is designed to give a fair picture of prenatal care, complications of pregnancy and delivery, and community and patient responsibility. A narrative report is also requested.

The committee sends such inquiries in regard to all deaths in which pregnancy or its outcome is mentioned on the death certificate. When difficulty or undue delay is encountered, the district member of the subcommittee helps the physician concerned to fill out the questionnaire.

Live-birth and fetal-death certificates or both are matched with the maternal-death certificates before questionnaires are forwarded to the physician concerned. Subsequently, the completed questionnaire is studied by the committee to be classified as preventable or nonpreventable by the patient, her family, the community, the physician, or the hospital. A report is sent to each physician related to the case as well as to the midwife if one has been involved. Where a health department or a midwife responsible to the health department has been in the picture, the maternal and child-health division is responsible for obtaining the necessary information.

Both the maternal and infant-welfare committee and the health department are aware that fetal and neonatal deaths are in large part a reflection of maternal morbidities and in some part of pediatric care or the lack of it. The study's emphasis on these items offers a vastly broadened approach to the problem of maternal and infant welfare over the traditional review of maternal deaths, particularly since the latter are decreasing steadily. All members of the committee are interested, for instance, in patterns of prenatal care and of analgesia and anesthesia, as related to infant-survival rates, and in patterns of care of the premature and newborn in relation to their survival or death rates.

Although the large number of fetal and neonatal deaths involved is prohibitive of complete and individual followup, the Georgia agencies also look forward to receiving valuable information from analyses of medical data reported on revised birth and death certificates. Eventually, a more detailed investigation of individual cases may be made on a sample basis.

The North Carolina State Board of Health in 1952 decided upon an intensive research study of fetal and neonatal wastage for use in future planning of the maternal and child-health program. The department obtained the services of the professor of biostatistics at the University of North Carolina School of Public Health, and with his help consulted the chiefs of obstetrics of the three medical schools in the State to design a 5- to 10-year study. Later the associate professor of pediatrics of one of the medical schools joined the group. The public-health statistics section, and the nursing, nutrition, and medical social consultants in the State health department all participated in planning the study. In addition, appropriate sections of the proposed schedule were submitted to an outstanding fetal pathologist for comment.

The plan of this long-range study calls for investigation, on a current basis, of fetal and neonatal deaths, of a quasi-control group of surviving infants, and of the mothers delivered in a group of hospitals. The investigation on infants is to include prenatal, natal, and postnatal phases, as well as detailed autopsy information. The data as planned are also to contain a complete history on the mother, coupled with some background information on the father.

The questions to which the participating specialists seek answers give an indication of the study's objectives. Some of them are: When other factors are constant, what is the influence of adequate prenatal care upon fetal and neonatal losses? How great is the influence of socio-economic factors in regard to pregnancy wastage and prematurity? How do different methods of delivery affect the baby's chances for health or survival? or different types and duration of anesthesia and analgesia? How can the baby's responses at birth be accurately described? How likely are these to be affected by type of delivery and method of pain relief?

The autopsy data will be brought to bear on the question of how closely they confirm reported causes of death, especially in instances of intrauterine anoxia, the presence of congenital anomalies, or cranial damage.

The study also involves basic objectives in statistical methodology. Owing to the complexities of collecting valid and reliable data to measure the intricate relationships in this field, a pilot study or "tooling up" phase is under way at the three teaching hospitals associated with medical schools in North Carolina. This will eventually be extended on a long-term basis to other hospitals interested in participating and able to comply with the study's design. Approximately 5,000 live births a year occur in the three teaching hospitals, and an estimated 150 fetal deaths and 100 neonatal deaths. During the pilot period of approximately 6 months, about 150 to 200 completed experimental schedules are expected to be collected, half of these on deaths and half on surviving infants.

The objectives of the study's pilot phase are:

1. To find out the difficulties the hospitals face in filling out the questionnaires.

2. To improve the schedule by eliminating ambiguities, inconsistent questions, or unanswerable questions, and to ascertain the general reliability of the answers received.

3. To learn the feasibility of the study's statistical design.

The statistical design as now being tested, provides for inclusion of fetal deaths regardless of duration of gestation, all neonatal deaths of infants born in the participating hospitals and occurring there, and for comparison a group of infants, born in the same hospitals, who survive the neonatal period. This group is selected by a randomizing procedure based on the terminal digit of the child's hospital file number. Thus, though the selection is determined while the mother is an inpatient the obstetrical staff is unaware before delivery which mother and child shall constitute a control if the infant survives.

In Hawaii the health department in cooperation with the School of Public Health of the University of California has undertaken a community-wide study on the outcome of pregnancy and associated factors with observations running concurrently with the course of pregnancy, beginning where possible soon after conception. The study is particularly concerned with the incidence of early fetal losses and with factors associated with such loss.

Stimuli for Study

Added impetus to special studies on fetal and neonatal mortality has come through the recent work of the subcommittee on causes of fetal death of the U. S. National Committee on Health and Vital Records. This was followed by the official revision of the standard certificate of fetal death by the National Office of Vital Statistics, which has greatly improved the outlook for securing more meaningful data regarding fetal mortality and conditions in the mother during pregnancy, labor, and delivery. The revised certificate, endorsed by the Public Health Conference on Records and Statistics, is recommended to the States for adoption in January 1955.

The American Academy of Pediatrics and the American Academy of Obstetrics and Gynecology are actively interested in reduction of fetal and newborn mortality through improving standards of hospital care of the newborn. To this end the Academy of Pediatrics has published the manual "Standards and Recommendations for Hospital Care of Newborn Infants—Full-term and Premature."[11] Included are suggestions for tabulating basic hospital statistics on fetal mortality and mortality of newborn.

In the space of this summary, only a few examples could be given of ways in which fresh facts are helping to guide maternal and child-health programs in meeting the challenge of fetal, neonatal, and maternal mortality. Generally speaking, current emphasis in the many studies under way seems to lie somewhat more upon the problems in neonatal and maternal mortality than on those presented by fetal loss. This emphasis reflects to some extent not only the importance of these problems but also the availability of well-tried statistical procedures for study of the maternal and newborn facets of maternal and child welfare. Current improvements in data on fetal loss point up a pressing need to widen agreements on basic statistical procedures for viewing the problems of fetal death, not out of context from maternal and infant mortality and morbidity, but as an integral part of the pattern of reproductive losses.

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Opportunities for program interpretation and community education lie ahead in . . .

EDUCATIONAL TELEVISION—PUBLIC SERVANT

BLANCHE CRIPPEN

Assistant Director, Public Information, Joint Committee on Educational Television

TELEVISION has more of a hypnotic attraction for youngsters than for adults. Many children spend from 10 to 15 hours a week in front of their sets, which amounts to a substantial percentage of their total learning experience. This makes it an important instrument for influencing their habits of mind and thought. It is also an accepted part of the lives of an increasing number of adults, exerting a similar, if perhaps not so deep, an influence on their habits and opinions as on those of children.

Who is to decide how this instrument shall be used? Will it be called upon to expand and multiply our educational and cultural resources—or left to become only a medium of superficial entertainment?

Request for Channels

The Nation's educators were among the first to ask these questions and to search for some answers. Believing that television has become a more powerful influence on people's minds than the printed word, they insisted that this new instrument of communication be allowed the same versatility as printing, which is accepted as a medium for both entertainment and education.

They stated their case before the Federal Communications Commission in 1950–51, claiming that the air waves, like public lands, constitute a public trust, and that a percentage of the television channels should therefore be reserved for noncommercial educational use.

The principle of reserving portions of the public domain for education has been fairly well established in this country since its earliest history. A series of land grants for the establishment of public schools in the colonies began in 1659. The Ordinance of 1785 relating to the Northwest Territory specified that "there shall be reserved the lot #16 from each township for the maintenance of public schools within the said township." With the admission of Ohio into the Union in 1802, Congress established the policy of setting aside lands for school support in each State formed from the public domain including land for the endowment of academies and universities.

The case for educational television was based on this historical precedent and upon the potentialities of the medium in extending and expanding educational services. A total of 838 colleges, universities, State boards of education, school systems, and public-service agencies presented written testimony to the FCC describing how they would use educational-television stations.

Professors proposed television courses for credit as an economical way to amplify university services. Adult-education specialists said television would encourage men and women to continue to learn new facts and skills throughout their lives, and to free themselves from the old pattern of school-career-retirement. School administrators suggested the use of television as a supplementary aid to classroom instruction. Public-service agencies and civic organizations emphasized the community's responsibility to provide good children's programs during appropriate viewing hours. Those responsible for the education of the homebound said television would enable them to increase their services and make them more effective without increasing travel costs. Teachers of young children pointed out the opportunity television provides of encouraging the preschool child to develop happy family relationships and desirable habits of recreation. Representatives of museums, art galleries, and symphony orchestras were enthusiastic at the prospect of visiting thousands of families via television and predicted renewed recognition and appreciation of the arts.

It was on the basis of these vistas that the Commission reserved 242 channels for education in April 1952. Since that time 10 additional channels have been reserved, making a total of 252.

Educational stations are now on the air in Houston; San Francisco; Cincinnati; Pittsburgh; St. Louis; East Lansing, Mich.; Madison, Wis.; Lincoln, Nebr.; Seattle, Wash.; and Chapel Hill, N. C. KTHE, Los Angeles, licensed to the University of Southern California, has temporarily suspended operations during a shift in plans for financial support.

Already several million people have educational-television stations within the reach of their receivers. As more stations now under construction are completed, it is estimated that their number will be between 35 and 40 million.

Cooperation Required

FCC policy requires educational-television stations to serve the broad educational needs of the community, rather than one institution or group. While this policy protects all community interests, and avoids the possibility of monopoly, it also poses a problem in human relations. All interested groups—schools, health organizations, medical institutions, social agencies, cultural organizations—generally use the same facilities, although the license is held by an accredited educational institution or a nonprofit corporation which includes one or more educational institutions.

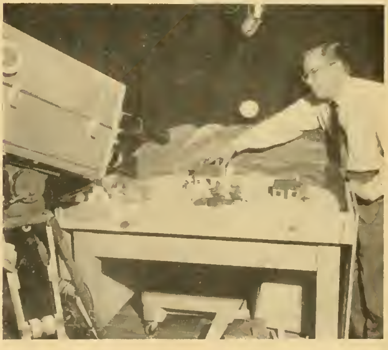
Hundreds of communities in all parts of the country have evidenced interest in procuring an educational TV station. Usually the move toward it begins with a few individuals who arrange a meeting to talk about the possibilities of building and operating a station. With publicity the community gradually becomes better informed; attendance at meetings increases; regional or State conferences follow. After a decision to proceed is reached, action becomes localized again, with committees, subcommittees, and study groups going to work on the problems of securing funds and developing a coordinated plan of action with educational institutions, civic and cultural agencies, and health and welfare organizations.

The pattern of organization develops slowly and not always smoothly. There are many variations, depending on the climate of opinion and the strength of support in each community. A university may be the coordinator in one area; the public schools in another; or the leadership may be found in a citizens group.

KQED in San Francisco, which went on the air in June 1954, is one outgrowth of joint community planning. It is licensed to the Bay Area Educational Television Association, a nonprofit corporation with a board of directors including representatives from elementary and secondary schools, colleges and universities, and other groups. Organizations represented on a citizens committee supporting the project include the Alameda County Teachers Association, the Association of Children's Librarians, chapters of the American Association of University Women, business and professional women's clubs, the Jewish Community Relations Council, the Music Teachers Association of California, the public library and the museum, the Girl Scout Council, the Teachers Association of San Leandro, and the Association of School Administrators. Financial support is provided by public subscription, public schools, and institutions of higher learning.

In Cincinnati on the other hand, the licensee, the Greater Cincinnati Educational Television Founda-

Educational television's programs for children mix wholesome entertainment with education in the arts and sciences. Here the sets are being arranged for "The Friendly Giant," a regular feature for the smaller of the small fry, offered by the educational-television station at Madison, Wis.



tion, is representative of educational institutions only, but 47 of these are included. Moreover, over 100 community groups supported the drive for funds. These included civic and cultural groups as well as public, private, and parochial schools; colleges and universities; boards of education.

Financing Educational TV

Continuous financial backing is important as educational stations cannot accept revenue from the sale of time.

Educational stations are being financed in several ways: by school and university budgets; by legislative appropriation; by public subscription; and by foundation grants.

Thirty-two States have appointed television commissions to conduct studies of the potentialities of educational television. Some have allocated funds for this purpose. In Alabama and Oklahoma the legislatures have provided funds directly for television stations.

In Denver, the public schools have earmarked $200,000 for the construction of a station and plan to share in operational costs. Additional funds are expected to be raised from public subscription.

In Cleveland, the public schools are taking an active part in planning for a station. Half a million dollars has been set aside by the board of education for construction purposes.

WKAR–TV, licensed to Michigan State College, East Lansing, is financed by university funds.

In Athens, Ga., the University of Georgia plans to build an educational-television station as part of its new Continuing Study Center, financed by the Kellogg Foundation, the University, and the State.

Ohio State University, expected to be on the air by the first part of 1955, is financing the construction and operation of its station.

WQED, Pittsburgh, the first "community supported" educational station in the country, has tapped three main sources of revenue: corporate and private donors; public, private, and parochial schools; public subscription. Some 60,000 families subscribe to "Program Previews," a monthly publication giving the program schedule and station news.

Many of these communities have received grants from the Fund for Adult Education, established by the Ford Foundation, through a fund-matching program which provides $100,000 to the community's $200,000 in selected localities. The Kellogg Foundation, the Old Dominion Foundation, and the Alfred P. Sloan Foundation, have also made grants for educational-television studies or stations, as have a number of other foundations.

National Organizations

Several national organizations have been established to provide assistance to groups interested in securing educational television for their communities:

The Joint Committee on Educational Television, 1785 Massachusetts Avenue NW., Washington 6, D. C., represents seven national educational groups: the American Council on Education, the Association for Education by Radio-Television, the Association of Land-Grant Colleges and Universities, the National Association of Educational Broadcasters, the National Association of State Universities, the National Council of Chief State School Officers, and the National Education Association. The committee provides legal, engineering, and programing consultant service to educators in areas where there are reserved television channels. It also conducts demonstrations for conferences, publishes information, and acts as liaison between the FCC and the educators.

The Radio-Television Services, Office of Education, U. S. Department of Health, Education, and Welfare, provides advisory services in programming, organization and technical aid to schools and colleges entering television.

The National Citizens Committee for Educational Television, Ring Building, Washington, D. C., was established to stimulate citizens' support and to assist in fund-raising campaigns for educational television. NCCET and the Joint Committee on Educational Television work together in aiding the development of this medium.

The Educational Television and Radio Center, Ann Arbor, Mich., has been established to develop television programs for use on educational stations, and to arrange for program exchange among the stations.

The National Social Welfare Assembly, Committee on Educational Television, was established in 1952 to examine the extent to which and in what manner the television channels assigned by FCC for educational purposes could extend their services to social agencies. The committee now serves as a clearinghouse for developments in educational and commercial television in regard to social welfare. It has devised a guide for a 2-day institute on television to help prepare social-welfare personnel to work with technical personnel in TV stations. The committee looks forward to developing a program

Scenes from two television programs which have been part of the medium's contribution to parent education. *Left*, Willard C. Olson, dean of the School of Education, University of Michigan, explains the meaning of organismic age in a telecourse, "Understanding the Child," produced by the university and broadcast over a commercial station. *Right*, Dr. Benjamin Spock, pediatrician, conducts one of his series on child care over Pittsburgh's community-sponsored educational television station.

series interpreting social-welfare problems and services to the public.

Programs on Educational Stations

The performance of educational stations to date has demonstrated the soundness of the educators' claims to the FCC. Programs have been developed for adult education, including instruction in the training of preschool children, and for classroom use at the elementary, secondary, and university levels. The stations have also produced programs for both children and adults emphasizing entertainment and an appreciation of the arts.

Since each station plans its program schedule in accordance with local needs and resources the emphases have varied with the communities. A study of station-program logs indicates that all educational stations devote the greatest proportion of time to adult education, including programs of general information and credit courses. Percentages of station time focused on family viewing is not as consistent. Some stations devote the next largest segment of time to this type of program; others spend more time on programs for school-age children.

Among other adult-education programs are a number directed to the adult's role as a parent. "Parents and Dr. Spock," a 30-minute program presented by station WQED, Pittsburgh, at 2:30 p. m. Tuesdays is an informal discussion on child care and development conducted by the well-known pediatrician, Dr. Benjamin M. Spock, with a group of mothers and special medical guests for them to "pick on." WQED reports that the program is stimulating home-study groups.

Home Nursing, a 30-minute program, was presented twice a week for 14 weeks during the early spring of 1954 by KUHT, Houston, Tex. The series was planned by the station staff and the American Red Cross, with Red Cross personnel as participants. The complete Red Cross Home Nursing curriculum was presented by means of lectures and demonstration. A total of 655 persons enrolled in the television course, with 365 completing it. The station estimates that 20,000 people regularly viewed the course.

Family Viewing

Programs of interest to all age groups are classified for "family viewing." They include dramatic presentations and other entertainment with cultural and educational values, as well as discussion programs presenting issues of interest to the entire family.

Educational-television stations, according to FCC regulations, are responsible for providing the public with different points of view on important public issues. Accordingly, the stations try to present the viewpoints of various facets of the community, allowing the participants to explore issues by means of intelligent discussion and to reach agreement as they see fit. During a recent 30-minute program called "Soap Box," a discussion of local issues, the manager of the St. Louis educational station allowed the program to continue for an additional half hour when it became obvious that the participants could not fully explore the subject in the scheduled period. A flexible program schedule, rarely feasible on commercial stations, made the time extension possible.

Children's Programs

Educational-station program logs already show a number of good children's programs. Some of these are scheduled during school hours and are planned to supplement classroom instruction in music, science, art, language, history, and health. Others provide a mixture of entertainment and education and are scheduled for out-of-school viewing. Outstanding among these last are "The Children's Corner," "The Finder," and "The Friendly Giant."

Children's Corner, a 1-hour program presented on Monday through Friday by WQED, Pittsburgh, is one of the most popular children's programs on the station. The *dramatis personae* consist of a hostess and her puppet friends with daily guests. There are foreign-language lessons, stories and drawing, and contests and prizes. The program receives more than 1,000 letters a week. WQED's manager calls this proof that "homicide is not a necessary adjunct to child entertainment."

The Finder, a 30-minute program, is presented by KETC, St. Louis, Monday through Friday at 4:30 p. m. With a peeping puppet it opens up new worlds for children between 9 and 12 years of age. One program included a visit to the crime laboratory of the local police department for a look at modern scientific methods of crime detection. Another featured the story of a young engineer who was developing an airplane that could land and take off in an area only 100 feet long. The Educational Television and Radio Center has selected this as one of the programs for distribution to other educational television stations.

The Friendly Giant, a 15-minute program presented by WHA–TV, Madison, Wis., Monday through Friday at 7:00 to 7:15 p. m., a program intended for small children, is one of the most popular features of the Madison station. Produced by a member of the University of Wisconsin staff, it includes stories and music for children, in an atmosphere of the world of fantasy. This program will also be distributed to other educational stations through the Center.

Community Responsibility

The development of educational television is one answer to widespread demands that "something be done" about television, for it provides a system of broadcasting which gives particular attention to the needs of children and youth. Following the interest shown in the effects of comic books on children by the Subcommittee to Investigate Juvenile Delinquency, of the Senate Judiciary Committee of the 83d Congress, some constructive measures have been taken by the comic-book producers, thus indicating how an alert citizenry can keep an industry sensitive to the impact of their product on children. The subcommittee's recent hearings on television may similarly stimulate more vigorous self-regulation in the television industry.

But congressional interest is not the whole answer to the problem of making this new medium of communication a constructive force. Parents, teachers, broadcasters (both educational and commercial), and the many different organizations and agencies of the community, including health and welfare groups, all bear a responsibility to see that this new instrument of communication is given wise direction, appreciation for good performance, criticism for poor performance, and careful, continuing supervision.

Television programs, like comic books, need constant study both by the public and by the television industry. Individuals and organizations can evaluate television programs in their own communities and bring public opinion to bear on those responsible for their presentation. Since television channels are limited, it is not censorship or unwarranted interference to call to the attention of the group entrusted with them the fact that they are being used wisely or unwisely.

Television presents a special opportunity to social agencies--both public and private—not only to interpret their programs to the community at large but to do the kind of community education that will prevent the health and welfare problems with which they have to grapple. While the demands on the public service time of commercial stations present formidable barriers to the local agencies seeking a medium for reaching the community, the educational station is a new and as yet largely unused door to the public. Those agencies that are eager to expand their services and the understanding of them will be alert to this opportunity.

An interprofessional panel considers ways of helping parents . . .

WHEN CHILDREN ARE BORN WITH DEFECTS

VICTORIA SHANNON

Medical Social Worker, Division of Crippled Children,
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MOST OF US who are engaged in health and welfare services have seen families which include a child with a congenital defect. We have seen the parents burdened with the extra tasks that caring for such a child demands and even more with the conflicting feelings they have about themselves and their child. We have wondered how they reacted to the child's birth. Could professional people have been more helpful? Can we learn to be of more help in the future?

To stimulate thought about helping parents in the period shortly after the birth of a child with a congenital defect, the Connecticut Branch of the American Association of Medical Social Workers sponsored a panel on the subject at its annual meeting held in conjunction with the 1954 meeting of the Connecticut State Medical Society. While problems of adjustment occur from the child's birth throughout life, the panel concentrated on ways of helping parents in the shock of their first knowledge of their child's anomaly. Since the most effective help to the child and his parents comes when physicians, social workers, and nurses work together, representatives of these three professions were each invited to contribute to the discussion.

Because of her studies of patients, the social worker in a prenatal clinic usually has knowledge of value to the physician considering how to help the parents. She may know the answers to such questions as: How did the parents feel about each other at the time of pregnancy? Has the marriage abounded in hostilities? Have the parents been accepted by their in-laws? Have the parents had to struggle with feelings of guilt over sexual activity or over their reaction to the pregnancy? Have cultural differences enriched their marriage or complicated their adjustment? Do they use religion as a source of support or a threat of punishment? Are there environmental difficulties which could be lessened? She has learned these answers in her efforts to build a relationship which may help support the woman not only during pregnancy but also after delivery.

The support given to the expectant mother by the nurse during pregnancy and good nursing care at the time of hospitalization are important in any

PANEL MEMBERS

John C. Leonard, M. D., *moderator*
Director of Medical Education and Clinical Director
Hartford Hospital

Katherine Davis, R. N.
Administrative Supervisor of Pediatric Service
Grace-New Haven Community Hospital

Alberta de Ronge
Medical social worker, Bureau of Maternal and Child Hygiene
Connecticut State Department of Health

Marguerite B. Gelinas
Medical social worker, Grace-New Haven Community Hospital

Paul Molumphy, M. D.
Assistant Professor of Obstetrics and Gynecology
Yale University School of Medicine

Morris A. Wessel, M. D.
Assistant Clinical Professor of Pediatrics
Yale University School of Medicine

pregnancy. The warmth of a good nurse can add much to a mother's feeling of confidence in her own abilities as a mother. This comes from both public-health nurse and clinic or bedside nurse. In addition nurses increasingly are becoming aware of the emotional implications of the patient's behavior and of the effects of personal problems on the patient's health and are bringing this understanding to bear in their handling of their patients.

The physician is the professional person of most importance to expectant parents. A significant part of his medical care is the reassurance that everything is going well or being watched and that he will be making the delivery safe. Since he appears as one who instills courage and strength he often engenders the kind of positive feelings formerly reserved for the husband.

Many physicians have found that most pregnant women have a suppressed fear of giving birth to a defective child. When this actually happens, "fantasy and reality appear to meet." [1]

The discussion of how the hospital team might help to lessen the nightmarish quality of this experience opened with a summary of a case known to the State division of crippled children. The baby, Jane, had a variety of congenital defects which made her anything but a picture baby. She received surgery in the general hospital shortly after birth and again at 4 months. She remained in the same hospital till she was 7 months old and was then transferred to an orthopedic hospital for children.

The mother was discharged at about the usual time after delivery. She rarely visited Jane either at the general hospital or at the orthopedic hospital. "I was so knocked out by the baby's condition that I hadn't the strength to get out of bed," she told the medical social worker when the family was referred to the division of crippled children.

This mother had been ill at home for over a month after her discharge from the hospital. Her upsetting experience was intensified by the attitude of her own and her husband's parents, her own refusing to see the baby and her husband's saying that she should not have had a child because she was too young to know how to take care of a baby.

Nevertheless Jane's mother was at this time in the fifth month of her second pregnancy and was terrified at the possibility of the coming baby being like her first. She hated to go to sleep because she always dreamed of deformed babies. All this came out after she had bombarded the social worker with questions about Jane—"How big is my baby? Does she sit up? How much does she weigh?"

Both the mother and father received enough emotional support from the social worker to become able to visit Jane and to move toward feeling themselves to be more loving parents and, therefore, better persons. In addition, they were relieved of the financial obligation they had incurred for Jane's care, even though they had not been able to see how they would meet it. Pressure for payment of overdue bills had aggravated the difficulty these parents had had in visiting their baby.

Mothers' Fears

After this case was reviewed the obstetrician pointed out that at the moment of birth a mother often fears that her child will be dead, injured, or defective. A mother may express this fear by asking, "Does it have all its fingers and toes?" Knowledge of a defect should not be kept from a mother when she asks, "How is my baby? Is he alive?" If the mother is to continue to trust the doctor, she should receive a frank answer. If she is told that the child is normal at this time her difficulty in eventually accepting the truth about her child's condition will be greatly increased. She may even insist that the defective child cannot possibly be hers. Learning that she was given false reassurance in the delivery room may provoke such resentment in both herself and her husband that neither may be able to establish good relationships with physicians in the future.

In the delivery room at the time of the birth of a defective child the doctor faces three immediate decisions: whether to tell the mother about the anomaly, to show it to her, and to discuss its prognosis. The panel obstetrician advised that in such a situation the mother must be told both about the anomaly and its degree of severity and should be shown the child unless it is greatly disfigured.

A more difficult decision, he said, is what to do if the anomaly is major and disfiguring. Usually the father wants to help. The mother's desire to see or not to see the child should be respected. Often the nature of the defect is less severe in reality than in the mother's imagination. Its prognosis should be discussed in general, leaving details in the hands of the appropriate specialist or a pediatrician.

The physician may find it very hard to tell the parents about a defect. The panel moderator mentioned how, as a young instructor, he had to force himself as well as the resident physicians to face this painful task. Some physicians may be especially reluctant to discuss the possibilities of mental retardation. Nevertheless in cases of brain damage it is unfair to the parents to let them continue to have false expectations, the moderator said.

The panel members questioned whether efforts to conceal the existence of a defect would always be successful. One told of a mother of low intelligence who said of her child: "I knew something was wrong. Nobody smiled or said anything; and he was blue, not like my other babies."

Another mother had been told only that her baby boy, who had a cleft lip, was alive. She had not been allowed to see him for 2 months while he recovered from surgery. Later when the child was 10 years old she told a social worker that at the time of his birth she had overheard people whisper the word "hare." Concluding that her baby was completely covered with a thick growth of *hair* she had refused to see him when she was at last given the opportunity to just before he was placed in a boarding home. The decision to place the child outside the home had been made by her family physician and her husband without consulting her. Her delay in seeing her baby and her exclusion from all planning had fixed in this mother the belief that her child was a monster.

Experience with mothers of infants with cleft lip has shown that they appreciate the skill of the physician more fully if allowed to see their children before surgery. More important, seeing the baby at once helps the mother accept him as an individual personality.

The Nurse's Role

The nurse pointed out that in dealing with a newborn child it is essential for all nurses coming in contact with the patient and family to know:

Whether the family knows the child is not perfect.

What information the physician has given the family.

How much information the physician wishes the nurse to discuss with the family.

Whether immediate corrective surgery is planned or whether correction will be postponed and for how long.

Old wives' tales often help to aggravate a mother's disturbed feelings—particularly a sense of guilt about her own responsibility for the defect. Nevertheless, she may hesitate or forget to ask her physician about the validity of what she has heard from her neighbors or elsewhere. The nurse has an opportunity to develop close rapport and learn some of the mother's concerns—sometimes these come out only while the mother is caring for or feeding her child. The nurse can reassure the mother and work with her and with the social worker and physician in planning ways of helping both mother and child.

Anxious parents frequently misinterpret a physician's remarks or cling only to the encouraging ones, so that they fail to face the facts. The nurse, who may be seeing the child and parent more frequently than either physician or social worker, is in a position by her own acceptance of the baby to help the parents to accept their child's limitations.

If the child is to undergo surgery the nurse should know what the physician has told the family concerning the operation, how many stages are involved, and what the possible complications may be. A reassuring experience for the family at this point may be to see a child who has had successful surgery for a similar condition, for example, cleft-lip repair or a heart operation. In the postoperative stage the nurse may help to reduce parents' fears concerning their child's condition when oxygen tents and other equipment unduly frighten them.

The Pediatrician

During the discussion, the pediatrician pointed out that a pediatrician if chosen before delivery can be of help to the obstetrician and the parents when the latter are informed of their child's defect. However, he warned against too much initiative on the part of the professional staff in urging the mother to see the baby. Emphasizing the importance of proceeding very slowly with parents, who naturally need time to learn gradually to accept their baby's abnormality and to become relaxed in the face of it, he pointed to the need for patience in dealing with them.

"We can be most helpful," he said, "by letting the parents talk about the child's handicaps, and how it affects them personally and as a family, how hard it is to feed the baby, how difficult it is to answer other children's questions, how they haven't been able to go out. These everyday problems are all important. As the parents relate these experiences and their feelings about them to the doctor, they learn that he is interested in them as well as in their child."

Each family must be understood individually by the pediatrician, who must see them regularly and plan his care in terms of months and years rather than in days and weeks.

"The parents are quick to notice impatience on the part of their doctor," the pediatrician added.

"When they feel that they are being rushed, they cannot be free and comfortable in discussing the problems, nor can they work towards making definite plans for the care of the infant."

Only when the parents realize that the pediatrician accepts them with all their mixed feelings and attitudes about their child, will they be comfortable with him. When they are, he may be the person with whom they will raise the question of whether they dare have another child—especially if they have any feeling that the obstetrician may have been at fault.

Future Pregnancies

The question "What about having other children?" is always asked sooner or later. When another child is on the way the mother and the father of a defective child will be seeking reassurance that misfortune will not strike again. In such instances, said the panel obstetrician, the obstetrician consulted must know about the parents' past experience in as great detail as possible, with particular emphasis on the manner in which the parents were handled by the medical personnel in attendance, what they have been told about the etiology and prognosis of the defect, and what their reaction has been to it. Only with these facts in mind and with a careful appraisal of the parents, based on close questioning, can he do his best to help with the parents' emotional problems. While there is some increased incidence of abortion, prematurity, and congenital defects in subsequent pregnancies among individuals who have had a congenitally defective child, it is not so great as to prevent an obstetrician from honestly expressing considerable optimism regarding the outcome of another pregnancy. "Such reassurance is extremely important," the obstetrician maintained.

Another case discussed involved the mother of a boy with a serious cardiac malformation. When her baby was about 3 months old, this woman had said, "It isn't fair for any baby to have so much trouble," and was very emphatic about never wanting another child. Two years later she became pregnant again. When she first talked to the clinic social worker, she was feeling very guilty about not wanting another child and had postponed talking to her husband and relatives or making any plan for obstetrical care. She said that her former physician had been very critical of her reaction to the birth of her boy, including her desire not to have another baby. Nevertheless she was thinking of going back to him again in spite of her resentment—perhaps to punish herself.

When the social worker helped her think of alternatives that would be more satisfying, her self-confidence increased and she was able to discuss with her husband some of her feelings. Together husband and wife worked out plans for medical care and took other steps to make everything about this pregnancy as different as possible from the previous one. However, this mother is still far more anxious than she was before she had a child with a defect and will continue to need the support of the pediatric clinic team even though her next baby is normal.

The obstetrician introduced another problem:

During pregnancy clinical signs and X-ray examination or both may disclose some weeks before term the presence of a major anomaly, especially hydrocephalus or anencephalus, gross malformations of the head and brain. This puts the obstetrician in a position of either deliberately concealing this knowledge from the parents, or of divulging the information to one or both of them. Frequently he handles the situation by informing the father about the anomaly, perhaps with the recommendation that it is up to him to decide whether or not to inform his wife. The obstetrician and the father may thus become partners in deliberately concealing the truth from the mother, a fact which may later be resented by the mother and have far-reaching repercussions. The father's emotions in relation to such a deception ought to be considered as well as how this will affect the wife's future feelings about her husband, the obstetrician said.

"On the other hand," the obstetrician added, "the mental state of the mother who knows that she is carrying a defective child is unfortunate and may possibly be reflected in difficulties in the further course of pregnancy or labor, depending on her personality and her deep feelings concerning childbearing, as well as on her past experience. We do not have in this situation the favorable maternal psychology which makes acceptance of knowledge of congenital anomaly relatively simple in the actual delivery setting."

The responsibilities imposed on the physician by foreknowledge of a defect are tremendous. The obstetrician cited a case in which a young husband was told of an expected hydrocephalic child. The father became greatly disturbed and told his mother. Promptly all the relatives became involved, each family blaming the other.

Sufficient knowledge about the family, the marriage, and the couple's feelings about the pregnancy might help the physician decide when and with whom he would talk. Such information would probably be known to the social worker or in some situations to a public-health nurse or to a medical student or physician who had had the time necessary to get such information and had learned how to use it.

The social workers suggested that a father told of an expected anomaly might gain emotional support from being able to talk over his problem with a social worker. The latter might help him to express his real feelings about whether to share this knowledge with the mother. A social worker might also help the father to realize how his handling of this crisis might affect the marriage. This clarification of the husband's feelings could be brought to the physician and used by him as a basis for further joint planning.

At this point in the discussion the pediatrician suggested that perhaps it was unfair for the obstetrician to unload his prebirth knowledge of defectiveness onto either parent before delivery. "There is too much emotional adjustment at stake to put the whole burden of knowledge on the father alone," he said. The pediatrician and obstetrician agreed that this whole area needs much further study.

The Social Worker

In discussing the making of long-term plans for families with defective children, the panel members maintained that the feelings and wishes of the family must be respected and that the parents should be the ones to consider the various ways of caring for their child. For example, advice to have a child placed in an institution may be disastrous to the parents if they are not ready to accept it.

Many parents have guilt feelings about having produced an imperfect child. Through the casework relationship the social worker often can help the parents to change their feelings about themselves so that they no longer blame themselves for their child's condition. Conflict between parents and among relatives over the child can then be reduced.

The same questions and problems may crop up again and again before real understanding and acceptance of the child are achieved. Some parents may need help in raising questions, such as whether their first reaction to the pregnancy affected the development of the fetus, or in asking about their child's prognosis or whether they should have other children. The social worker and other members of the professional team may also facilitate cooperative relationships among the various hospitals or clinics that may be involved in the case.

In some instances the pediatrician or family physician may have the interest, time, and skills to help the parents with their planning. Because of the length of time involved, and the complexity and cost of the services required, many physicians refer their patients to the local unit of the State division of crippled children, where the child can receive coordinated care from a team of medical specialists, nurses, social workers, and speech, occupational and physicial therapists. Other private, voluntary, or tax-supported resources are drawn in on the patient's behalf.

Frequent communication between the various professional persons involved is essential in working with families of children with congenital anomalies. For example, if the child has cerebral palsy many persons will have different services and points of view to offer—all needed by the patient at one period or another. If the family is to participate there must be such close working together of the professional people that the family will see unity in approach and goals, even with variety of personnel and method. Spending time in a case conference can save time by increasing the effectiveness of work with the patient.

As the professional personnel involved we also need to learn much more about our own feelings concerning parenthood, the processes of pregnancy and childbirth, persons with defects—and how these feelings affect our work. We need to learn much more about the meaning of these experiences to other people so that we can understand different parents' reactions to them.

In our daily work with expectant parents, we need to make use of our opportunities to help build their confidence and move toward more effective adulthood. When a child is born with a defect we need to accept his parents' feelings, and to realize the individuality in each situation. We must assist such parents from the beginning in understanding what is involved in their child's treatment and prognosis—that several operations at different periods of a child's life may be needed, that training of a special sort may diminish a handicap, that help can be given them in relation to their own feelings. In short, we need to use our professional skills with the greatest understanding of which we are capable.

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[1] Mushatt, Cecil, M. D.: Multi-Discipline Services in an Obstetric Clinic, paper presented at the 1954 Forum of National Conference of Social Work.

TRENDS IN FAMILY LAW ADMINISTRATION

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THE JUDICIAL SYSTEM is going through an important period of change in its administration of cases involving family disorganization. This change is being forced by the swelling numbers of cases arising from family breakdown, the development of new knowledge about human behavior in the family setting, the increasing significance of social work and other comparatively new professions in providing services to disorganized families, and the growing realization that many traditional legal methods fail when applied to family cases. Such centuries-old legal devices as the advocate system, rules of evidence, fault as the basis for declaring legal rights, and punishment of the guilty have been found wanting when applied in many types of family law matters. Most lawyers and judges well trained in law and highly respected in their profession are incapable of dealing competently with these cases. Their incompetence stems not only from too little knowledge of the new sciences and services in the family field but often from prejudice against them.

The present period of change in judicial organization, procedure, and personnel as applied to family disorganization began around 1900 with the establishment of the first juvenile courts, set up to treat children in trouble not as criminals but as individuals needing the care and guidance of the best community resources available. All States now have statutes providing for special informal procedures for handling juveniles. Dispositions often involve the cooperation of many government and private agencies. Some juvenile courts have able and understanding judges aided by trained staffs which may include social workers, probation officers, physicians, psychologists, and psychiatrists. While today most courts having juvenile jurisdiction are inadequately and insufficiently staffed, the principle for which juvenile courts were established is entrenched in the State juvenile-court acts, and the trend is toward bringing administration of the acts more fully into line with it.

Juvenile-court jurisdiction usually is restricted to dependent, neglected, and delinquent children. Yet these are only a few of the many types of court cases involving family disorganization with which the judicial system must cope. Others are divorce, annulment, child-custody and support controversies between parents, alimony, disputed paternity, support of indigent parents, consent to marriage of a minor, and such criminal proceedings as contributing to the delinquency of a minor, family nonsupport, adultery, and assault and battery by one family member on another. Hundreds of thousands of such cases are instituted annually in the United States and jurisdiction over them is divided among many courts. In some States, every court in the State has some aspect of family disorganization in its jurisdiction.

Family Courts

This situation has given rise to proposals for the establishment of family courts—courts with jurisdiction over all cases involving family disorganization and served by a staff of trained specialists to make investigations for the court, advise it, and provide marriage and family counseling to those before it. A family court so conceived is essentially a juvenile court with much broadened jurisdiction. A few courts have all of these characteristics but their jurisdiction falls short of the family-court objective.

Impetus has been added to the family-court movement by a recently published report, *Children and Families in the Courts of New York City*,[1] made by three lawyers, Walter Gellhorn, Jacob Hyman, and Sidney Asch. Based on a study sponsored by the Association of the Bar of the City of New York the report also includes recommendations of a special committee of the association. It describes the administration of the various courts that deal with family cases in New York City: The Domestic Relations Court and its special branches, Children's Court and Family Court; Magistrates' Courts; Court of Special Sessions; County Courts; Supreme Court; and Surrogate's Court.

"The methods of dealing with family problems in New York are shockingly inadequate," the authors conclude.

The recommendations urge a State constitutional amendment creating a new, integrated court for New York City, with jurisdiction over substantially all family-disorganization cases. This, they suggest, should be manned by specialized judiciary with appropriate training for family-disorganization cases, appointed by the mayor, and an adjunctive staff of professionals to provide social casework, counseling, probation, medical, psychological, and psychiatric services coordinated with the service of qualified religious and philanthropic agencies.

The study's conclusion of present inadequacy derives from many factors besides the fragmented nature of jurisdiction over family problems.

The intake service of the Children's Court does an insufficient job of screening and needs a more ample staff of fully professional people. The professional standards and salaries for Children's Court probation officers are too low to attract a satisfactory staff, and the caseload per officer is too high as is staff turnover. Detention and commitment facilities for children are overcrowded. Many children who need long-time foster care must be returned to their unsatisfactory home environments because there is no other place for them. The situation is complicated by the tendency of private institutions to take only the less seriously maladjusted children, thereby concentrating the troublesome, difficult cases in the public institutions. Court investigations of private adoption placement are less searching than they should be because of the caliber of the investigators and the anti-social-worker complex of some surrogates. Investigations in child custody and support cases are too few and when made show little scientific understanding of human personality. Custody agreements made by divorcing parents are often given effect when they operate against the best interests of the children involved. The courts lack sufficient factual data to evaluate their desirability.

Some Obstacles

It was not within the assignment of the study staff or the recommendations committee to suggest ways of overcoming the obstacles that lie in the way of achieving an integrated court. Nevertheless, these must be faced. Opposition can be expected from the courts that will lose jurisdiction if a new court is established, from economy blocs that oppose any new government expenditures, and from conservative elements in the bar that dislike the idea of unorthodox court procedures and multiprofessional staff.

The report is vague about how extensive the changes should be in divorce and annulment procedures, cases of importance to the livelihood of private practitioners of the law. Should there be independent court investigations in all support and custody matters and mandatory marriage counseling in all divorce cases? Should administrative boards be given fact-finding and decision-making powers? Should the authority of judges who are lawyers be curtailed? To what extent should the work of private practitioners of the law be superseded by the work of court personnel? The report also fails to mention the possibilities of professional schools of law, social work, and medicine providing better training in family-law administration and developing an appreciation of the potential contributions of each profession.

While it leaves some questions unanswered, *Children and Families in the Courts of New York City* is an important work not only as an excellent case study, but also as an illustration of the legal profession's increased understanding of the problems of family-law administration and its willingness to assume more responsibility for their solution. It seems inevitable that moves toward juvenile-court principles and consolidated jurisdiction will inevitably take place in regard to all types of family-law cases. But whatever the ultimate nature of family-law administration, the legal profession will remain influential in this field.

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[1] Gellhorn, Walter, Hyman, Jacob, and Asch, Sidney: Children and Families in the Courts of New York City. New York. Dodd, Mead & Co. 1954. 403 pp. $5.

BOOK NOTES

TAKING HOLD OF TELEVISION: a guide for health, welfare, and civic organizations. Roger S. Hall. National Publicity Council for Health and Welfare Services, New York. 1954. 119 pp. $2.

This companion piece to the Publicity Council's guide to radio production by nonprofit organizations (issued several years ago) offers help to groups that wish to produce noncommercial television programs. Much of the author's advice concerns techniques in TV production, but speaking for TV viewers, he reminds would-be producers that "we also demand showmanship and human interest and imagination."

RECREATION FOR COMMUNITY LIVING; guiding principles, by participants in National Recreation Workshop. The Athletic Institute, 209 S. State Street, Chicago 4, Ill. 1954. 167 pp. $1.25.

A group of recreation leaders, including heads of college training programs, administrators of recreation and park agencies, and others, meeting at a 10-day workshop, have contributed to the formulation of the "guiding principles," offered in this report. The section on principles is preceded by a discussion of recreation in American life, including development of kinds of recreation from the colonial period to the present; the significance of recreation to the individual and family; and organizational patterns of recreation.

SPIRITUAL VALUES IN CAMPING: what they are, and how to put them into campers' lives. Clarice M. Bowman. Association Press. New York. 1954. 240 pp. $3.

This YMCA publication is one of a series of "guides to camping and faith." The author believes that when camp directors plan the camping season "there can be a more inspiring sense of mission and challenge—not only in terms of life in a rustic situation, or of opening to young folks the wonders of their world, or in terms of group life, but in terms of helping each individual in the camping situation experience to the fullest his life-potential . . ."

THE NURSE IN THE PUBLIC HEALTH PROGRAM. Pearl Parvin Coulter, R. N., M. S. G. P. Putnam's Sons. New York. 1954. 309 pp. $4.75.

"The ideal nurse," says the author, ". . . has come to realize that no matter how well prepared educationally, how skillful in scientific procedures, or how well fortified with wide experience, the individual professional health worker cannot, singlehanded, give those whom she would serve all of the help which they need. She knows that an assortment of skills, disciplines, and personalities is needed to provide effective health services to any community."

Recognizing the importance of teamwork, the author has planned this book to "assist in the orientation of the student nurse toward public health and to suggest some of the techniques which will help her to gain facility in the complicated area of interpersonal and intergroup relationships."

GUIDE LINES FOR GROUP LEADERS; the why and how of group work. Janet P. Murray and Clyde E. Murray. Whiteside, Inc., and William Morrow & Co., New York. 1954. 224 pp. $3.95.

Addressed to untrained people, this book is planned to help them work as leaders of groups sponsored by local social agencies, churches, and national organizations such as Y's, Scouts, and other youth-serving agencies. The authors state principles and offer practical suggestions on group leadership.

PROBLEMS OF INFANCY AND CHILDHOOD; transactions of the seventh conference, March 1954, sponsored by the Josiah Macy, Jr. Foundation. Edited by Milton J. E. Senn, M. D. The Foundation, New York. 1954. 196 pp. $2.75.

A transcript of informal group discussions of five conference papers constitutes the main part of this report. The subjects include: application of psychological theories concerning the bringing-up of children; effects of separation of mother and child during hospitalization; emotional life of children in communal settlements in Israel; and individual tendencies in the second year of life. The book also includes a subcommittee's report on hospital "rooming-in" of mother and baby after childbirth.

THE CHILDREN GREW. Eleanor Choate Darnton. Crown Publishers, Inc., New York. 1954. 199 pp. $3.

This is a story of how one mother brought up her two young sons without their father, who was a war casualty. Covering the growing years from 1 to 12 in the lives of the two boys, the book touches on many of the problems that concern all parents but seem particularly difficult to a mother rearing her children alone. In anecdotal form, it allows the reader to draw his own conclusions and is as much a story of how a mother learns as how children grow.

GUIDE TO STANDARDS FOR RESIDENT CAMPS FOR CRIPPLED CHILDREN. National Society for Crippled Children and Adults, Chicago. 1954. 29 pp. $1.50.

In outline form this guide offers standards for physical plant and equipment, admission policies and procedures, health and sanitation, safety, administration, program, and personnel, for camps for crippled children. Appendixes list types of National, State, and local resources available for use in establishing and operating a camp, and some legal and insurance problems that may arise.

GUIDE TO COMMUNITY ACTION: a sourcebook for citizen volunteers. Mark S. Matthews. Harper & Bros., New York. 1954. 434 pp. $4.

This sourcebook is planned to help citizens' groups contribute to their community's welfare. Among the fields important to children and youth in which the book suggests action are: home and street safety; recreation; family-life education; and handicapped children. Each chapter is followed by several pages listing sources of aid and a separate section on sources of films and film information.

PROJECTS AND PROGRESS

Juvenile Delinquency

Reflecting its greatly increased emphasis on prevention and treatment of juvenile delinquency the Children's Bureau is establishing a Division of Juvenile Delinquency Service. Major functions of the new Division center on giving technical aid and consultation to the States in regard to the various aspects of juvenile-delinquency control such as: coordination and planning of community services; treatment and rehabilitation of delinquent youths; training personnel for services to delinquents. It will develop standards and guides for program policies; make surveys of services and facilities; and provide direct consultation to States, localities, and professional schools on training and administrative problems. It will also collaborate with voluntary organizations on the development of programs and training of personnel.

The expansion in services is being financed from the $75,000 supplementary appropriation made to the Bureau by the 83d Congress.

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Representatives of national organizations and Federal agencies concerned with juvenile delinquency met in Washington November 22 at the call of the Subcommittee to Investigate Juvenile Delinquency, of the Senate Committee on the Judiciary, of the 83d Congress. Purpose of the meeting was to obtain the widest possible agreement on recommendations proposed for inclusion in the subcommittee's report. One point of agreement was on the desirability of establishing a national coordinating mechanism to give leadership to planning efforts towards stimulating local action against juvenile delinquency. The group also agreed on the need for Federal grants for research, training, special services and State planning and coordination.

Among the organizations represented at the conference were: the American Bar Association; the American Public Welfare Association; the Administrative Office of the United States Courts; the Advisory Council for State and Local Action, of the Midcentury White House Conference on Children and Youth; the Bureau of Prisons of the Department of Justice; the Child Welfare League of America; Community Chests and Councils of America; the Family Service Association of America; the National Association of Training Schools and Juvenile Agencies; the National Council of Juvenile Court Judges; the National Education Association; and the Youth Division of the Federal Parole Board; and various units of the U. S. Department of Health, Education, and Welfare.

Early in the fall the Subcommittee released a transcript of its hearings on crime comic books. These hearings, held in the spring of last year, have resulted in a code of standards being adopted by a large proportion of the industry, and appointment by a group of publishers of a "czar" to enforce the code.

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A 5-year program to fight juvenile delinquency was announced in November by the National Probation and Parole Association. The program is being financed by the Ford Foundation with a $600,000 grant. For the first 18 months the work will be restricted to selected localities in a few States, where investigators will study facilities available to cope with delinquency, determine unmet needs, and find out what is being done to bring together public and private groups in efforts to help young law violators.

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The Juvenile Protective Association of Chicago is joining with the city police department in bringing social services to some of the children picked up by the police for offenses not serious enough to require referral to juvenile court. The association has opened a branch office in one police district, and is accepting referrals from juvenile-police officers and policewomen. In most cases the children referred are very young, or are first offenders.

Because delinquency in New York City is increasing much more sharply among youths 16 to 20 than among children under 16, the New York City Youth Board, a public agency financed by the State and the city, is expanding its preventive program for older teenagers. Delinquency figures for the first 6 months of 1954, compared with those for the comparable period of 1953, showed that the increase among boys and girls 16 to 20 coming to the attention of official agencies as the result of delinquent acts was almost three times as great as the increase among the younger group.

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Twenty-three State training schools for delinquent boys have Boy Scout units, and a number of others are planning to establish such units, according to a member of the National Committee on School Relationships, Boy Scouts of America. Most of the units are sponsored by the schools which use State funds for their support. Others are sponsored by outside organizations, such as Rotary, Kiwanis, Shriners, American Legion, Elks, and the FBI. The program is most popular among boys under 15. This information was collected by the superintendent of the State Home for Boys, Jamesburg, N. J.

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In the District of Columbia the Commissioners' Youth Council has initiated a long-planned experimental approach to the problem of juvenile delinquency, focusing on two elementary schools, with a total enrollment of about 1,000 children. The District's education, health, welfare, recreation, and police departments have agreed to place additional personnel in the two schools. Smaller classes—no larger than 30 pupils—will permit teachers to give children more individual attention and to recognize their special problems.

Migrants

Meeting in the White House October 14, 1954, the Federal Interdepartmental Committee on Migratory Labor, a Cabinet-level group created by President Eisenhower, resolved to see how much can be done for migrants under present authority. The committee consists of the Secretaries of Agriculture; Health, Education, and Welfare; the Interior; and Labor; and the Administrator of the Housing and Home Finance Agency. The Secretary of Labor serves as chairman. A work group representing various agencies within the departments has been appointed by the committee members. The Committee is also setting up subcommittees to study and make recommendations on specific problems such as migrant housing, including standards for labor camps and methods of financing good housing; safe transportation of workers, and encouragement of State migratory labor committees.

Detention and Shelter

The report of a 2-year study of facts about children who require temporary care away from home, and of social services to prevent separation of children from their families, has recently been issued by the California Committee on Temporary Child Care, appointed by the Governor's Advisory Committee on Children and Youth.

Entitled "California Children in Detention and Shelter Care," the report sets forth standards and goals for detention of children awaiting court action for delinquent acts and tells how detention is used in California. It defines the difference between detention and shelter, two forms of care which, it notes, are often confused. Shelter care, the report explains, is a form of protective service, required mostly by small children who have not been taken into custody for delinquent acts, but who may be homeless or destitute. Unfortunately, it reports, many children who are not delinquent are kept in detention because facilities for shelter care are lacking. No distinction is made between these two forms of care in the California law.

The committee recommends this and a number of other changes in the State laws. It urges that responsibility for basic services to children be fixed by law so that groups of children are not left unprotected. It recommends that the juvenile-court law be amended to conform with the Standard Juvenile Court Act so as to eliminate the practice of arresting and detaining children under the penal code. It suggests amending the Welfare and Institutions Code to forbid the detention of children in jail and to provide shelter facilities for children who do not require secure custody.

Some of the other recommended amendments would: provide for medical examination of all children upon admission to detention or shelter facilities; authorize county welfare departments to provide protective casework services when needed; and require the State Youth Authority to set standards for detention, to inspect detention facilities, and to expand consultation services.

Among other recommendations are some that can be carried out without change in the laws. For example, the committee notes that joint action by counties in building detention homes is permitted by the law, and urges counties to take such action.

Copies of the report may be obtained from California Committee on Temporary Child Care, 401 State Office Building No. 1, Sacramento 14, Calif.

American Indians

States are making progress in enabling American Indian children and adults to receive community services on the same basis as other citizens, rather than through special services from the Federal Government, according to the Bureau of Indian Affairs, Department of the Interior, but many problems of health, education, and welfare remain to be solved.

More Indian children are now attending community schools—public, parochial, and private—instead of Federal boarding schools. Some Indian youngsters are also becoming integrated into the community—staying in town Monday to Friday, living in dormitories or foster homes during the school week and going home to the reservation for weekends. But many Indian children are still in Federal schools, and some are not in school at all.

An increasing number of States—but not all—are providing child-health and welfare services and general assistance to Indians on the same basis as to other citizens. But many State programs are not adequately staffed or financed to provide the services needed.

In relation to children and youth the Bureau of Indian Affairs is especially concerned about the high incidence of tuberculosis and other diseases and the high mortality among infants less than a year old; the need for protection of children's rights in those tribes with which Federal arrangements are being terminated; the large number of children sent to Federal boarding schools because of social problems rather than for educational reasons; and the 5,000 Navaho children of school age who are not attending any school. This number was reduced from 13,500 during the past year through the Indian Bureau's strenuous effort toward school enrollment.

. . .

Navaho Indians living on reservations in the Southwest are learning about the child-labor and other provisions of the Federal Fair Labor Standards Act through broadcasts in their own language. Through cooperation between two Government agencies—the Department of Labor's Wage and Hour and Public Contracts Divisions and the Department of the Interior's Bureau of Indian Affairs—explanations of the act are prepared for a radio station in Gallup, N. Mex., where they are translated and broadcast in the Navaho language.

. . .

For the past year Indian families on reservations in Oklahoma have been receiving health services from county health departments through an arrangement between Oklahoma's State Health Department and the Bureau of Indian Affairs, U. S. Department of the Interior.

Hospital Care

The Committee on Hospitals and Dispensaries of the American Academy of Pediatrics has recently completed a guide for hospital care for children.

According to the committee's report, the guide has been planned to provide benchmarks for either evaluating an existing pediatric service or initiating a new one. It includes only basic principles, arrived at in the light of changes occurring in the practice of pediatrics, and leaves the details to be developed by individual hospitals. It does not set forth minimum standards, but rather suggestions for developing the best possible care, and is primarily designed to help general hospitals, rather than special hospitals for children.

Noting that a hospital facility accepting children must accommodate not only a variety of illnesses, but a variety of age groups, each with its own peculiar characteristics and needs, the committee maintains that the hospital has responsibility not only to provide a high quality of medical care to the children accepted for care, but also to serve their needs by adapting the services to their individual characteristics—emotional, physical, and other.

The committee offers the report as a beginning, "of what, it is hoped, succeeding committees of the Academy may revise and expand until it more fully realizes the goal of a useful and comprehensive guide." It suggests that the guide when sufficiently developed will serve a purpose similar to that of the Academy's "Standards and Recomdations for Hospital Care of Newborn Infants, Full-Term and Premature."

Copies of the report may be obtained at 25 cents each from the Office of the Academy, 1110 Church Street, Evanston, Ill.

Fluorides in Water

Philadelphia with its 2 million people has recently been added to the more than 1,000 communities in this country whose water supply is fluoridated by local health authorities as a step toward preventing dental caries in children. According to recent estimates, more than 20 million people in this country are now drinking fluoridated water and nearly 5 million more will be doing so when Chicago and St. Louis begin fluoridation, scheduled for early in 1955. The figure will be considerably swelled if New York City accepts the recent recommendation of its Board of Health for fluoridation.

In spite of these large-scale moves toward fluoridation, proposals to add fluorides to the public's water supply failed to receive support in the majority of communities where they were put to a vote in last November's elections—with 16 communities rejecting the suggestion and 4 accepting. Two communities discontinued fluoridation.

Controlled fluoridation has been endorsed by the American Academy of Pediatrics, American Dental Association, American Medical Association, Association of State and Territorial Health Officers and other national organizations.

For the Handicapped

An in-patient rehabilitation center for severely handicapped cerebral-palsied children recently opened in one of New York City's public hospitals. Sponsored by the United Cerebral Palsy of New York and New York Medical College and operated in conjunction with the city department of hospitals, the center will be partly financed by State funds.

Part of a larger unit for severely handicapped children the center has facilities for 40 patients, 6 to 21 years of age. It offers complete care, including medical treatment; physical, occupational, and speech therapy; education; recreation; and other services to meet the psychological and social needs of the patients. In connection with these services, a research and teaching program will be supervised by New York Medical College.

* * *

Training for 10 graduate students to qualify as clinical psychologists with special competence for research in mental deficiency began recently at George Peabody College for Teachers, Nashville, Tenn., through a grant from the Public Health Service, U. S. Department of Health, Education, and Welfare. The project is guided by the college's department of psychology, which will be joined by Vanderbilt University in providing specialists in fields that bear on problems relating to mental deficiency, such as psychology, education, medicine, and sociology. Neurologists, endocrinologists, and neurophysiologists are available through Vanderbilt University's Medical School. Institutions operated by the Tennessee State Department of Mental Health, such as the State training school for the mentally deficient, will be used as sources for research.

Adoption

Two international agencies concerned with adoption of overseas children recently merged—the American Branch of International Social Service, of New York City, and the International Adoption Association, of Hollywood, Calif. The merged agency will keep the name International Social Service and will maintain both the New York and the Hollywood offices. . . . The Health and Welfare Council of New York City has recommended that the city's department of welfare establish an adoption service for children "as soon as possible in 1955."

* * *

Procedures that a community group can use to determine fiscal ability in relation to planning for the support of health, welfare, and leisure-time services are outlined by the Massachusetts Community Organization Service, Boston, in a bulletin, "Toward Solving the Puzzle." The bulletin suggests methods of evaluating a community's present program and of charting its fiscal resources. For comparative purposes it shows for 20 small cities the amounts of public and private funds expended in 1951, 1952, and 1953 for health, welfare, and leisure-time services, as well as the amounts collected through voluntary fund-raising. Both total and per capita figures are given.

* * *

Suggestions to help those who deal with children—their own or other people's—are offered in a booklet recently published by the Board of Hospitals and Homes of the Methodist Church. Entitled "Who Matter Most—Today's Children," the suggestions cover such subjects as family living; behavior difficulties; building self-confidence; sex education; vocational choices; religious development; and the significant adult in the child's life. The booklet is written primarily for foster parents.

In Print

"As a beginning effort toward the goal of a real directory," according to the National Association on Service to Unmarried Parents, the Association has issued a listing of maternity homes, with the title "Maternity Home Resources for the United States and the Territories." The bulletin is available to health and welfare agencies at 50 cents, from the Association, 8615 Euclid Avenue, Cleveland 6.

* * *

Eight essentials are listed by the National Association for Mental Health in a leaflet, "What Every Child Needs for Good Mental Health." Pointing out that children's emotional needs are as important as their need for food and sleep, the leaflet says that "to have perfect health—to be both healthy and happy, all children require love, acceptance, security, protection, independence, faith, guidance, and control."

* * *

Youth and Work, a new quarterly newsletter published by the National Child Labor Committee, has been established "to meet the need for a clearinghouse of information on projects and materials that are helping young people make the transition from school to employment." Persons connected with schools or youth-serving agencies who are interested in receiving the newsletter should write to the Committee at 419 Fourth Avenue, New York 16, N. Y.

IN THE JOURNALS

Family medicine

Carrying out the idea that the best education is self-education, the new medical school at the University of California at Los Angeles offers a course in family medicine which enables the student to see patients from the beginning of his studies and introduces him to the basic subject of growth and development. A report of this course "The Family in Medical Education" appears in the October 1954 issue of *Pediatrics*. This work, which continues throughout the student's 4 years of study, emphasizes the relationship of the psychologic, economic, and sociologic aspects of the patient's environment to disease.

Gaps in maternity care

In a study in 1951 in New York City, the date of the serologic test for syphilis (STS) during pregnancy, indicating commencement of prenatal care, was studied in relation to other data on birth certificates. The findings of this study are reported in *Public Health Reports* for October 1954, under the title "Prenatal Care in New York City, 1951," by Leona Baumgartner, M. D., Ph. D.; Edwin M. Gold, M. D.; Harold Jacobziner, M. D.; Helen M. Wallace, M. D.; Louis Weiner, E. E.; William M. Schmidt, M. D.; and Jane Worcester, Dr. P. H. They showed striking differences in the proportion of late or no STS, according to the type of service used in the hospital, the type of hospital where delivery occurred, and the residence of the patient. The authors point out that such information can be a valuable guide to local health officers in focusing prenatal-care programs and services on areas of greatest need.

Nurses in the Middle East

Public-health nursing is becoming an accepted part of the health picture of the Middle East. How this has come about is reported by Margaret E. Willhoit, nurse officer of the Public Health Service, U. S. Department of Health, Education, and Welfare, in the October 1954 issue of *Nursing Outlook*. In an article called "First There Were None and Now There are 48," Miss Willhoit reports that when she joined the staff of the Foreign Operations Administration at the American University at Beirut, Lebanon, in 1951, to administer and teach the public-health nursing course, there were no such nurses in the Middle East. Since that time, 48 nurses from 8 countries have been graduated from the course.

A limit to freedom

In an article "Public Health and Religious Freedom" in the October 1954 issue of *American Journal of Public Health*, James A. Tobey, member of the New York Bar, cites court decisions to show that: "Freedom of belief may be absolute, but freedom of action is not." The courts of the country, the author states, have always ruled that public health must prevail when religious freedom has come in conflict with public-health laws, medical-practice acts, and laws requiring adequate medical care for minor children.

The problem of comics

There is no easy answer to the problem of the undesirable comic books, Judge Thomas L. Zimmerman, of the Juvenile and Domestic Relations Court, Bergen County, N. J., states in "What To Do About Comics," lead article in the September 15, 1954, issue of *Junior Libraries*. In the battle against undesirable comic books, the first line of defense is the home, Judge Zimmerman maintains. Says he: "The parents who read to their children from an early age can fairly hope to give them interests and discrimination such as will see them safely past the shallow lures of the crime comics."

Setting the public straight

There is a great deal of public misconception about the social worker and what he does, and a great deal of ignorance about the various public and private agencies operating in the social-work area, Herbert F. Kretchman, editorial writer for the Salt Lake Tribune, Salt Lake City, Utah, states in an article "Public Relations in Social Welfare" in the October 1954 issue of the *Social Work Journal*. Mr. Kretchman advises members of the social-welfare profession of many things that need to be done to remove the confusion and to set the public straight, such as: defining and delimiting their profession; emphasizing the personality adjustment phase of social work; counseling in but not leading or directing social reform.

Feeding "excesses"

Charging that a great many excesses have been committed in the name of "demand feeding" Joseph H. Lapin, M. D., New York City, reports on a review of such practices in "Common Errors in Infant Feeding," in the *Journal of Pediatrics* for November 1954. Dr. Lapin maintains that if the effect of each new formula and food is observed and tested the result is likely to be far more rewarding than any catchword phrase, such as the current "streamlined plan of infant feeding."

The press and the courts

In an article, "Newspaper Publication of Names of Juvenile Offenders," in *Focus*, September 1954, Fred W. Woodson, director, Juvenile Court of Tulsa County, Okla., cites poor public relations as one of the reasons why this controversial issue has assumed such proportions. Much of the reason why the juvenile court and the press are "at each other's throats" centers around the "silly" stereotypes they have of one another, the author asserts. Both will be closer to reaching their common goal—the prevention and reduction of delinquency—when those stereotypes are erased, he maintains.

Dental supply and demand

Of the 84,000 dentists who are active in this country at the present time only 127 are listed as specialists in children's dentistry, according to a report in the November 1954 issue of the *Journal of the American Dental Association*. The report, the "Status of Dental Personnel in the United States (1954)," shows that although the number of practicing dentists is steadily increasing, the demand for dental care is also growing. As a result, the problem of making dental care available to everybody who needs it is still formidable.

Psychiatrist and social worker

No matter how valuable a contribution a psychiatrist makes in consulting with a casework agency, his contribution of necessity must be supplementary to the agency's treatment program, says Viola W. Bernard, M. D., College of Physicians and Surgeons, Columbia University, in "Psychiatric Consultation in the Social Agency," in the November 1954 issue of *Child Welfare*. In the agency setting, the psychiatrist and the social worker perform together on an equal basis, for each has his own knowledge and contribution, the author explains. Using clinical examples, she describes how the psychiatrist gives direct treatment to a child and how he helps a child through consultation with the agency.

They are all children

The Pacific Oaks Friends School in Pasadena, Calif., is attended by more than 100 boys and girls from 2 to 6 years of age, of various creeds and nationalities. They include a small number of children with slight brain injuries, some with emotional disturbances, and some who are blind.

In the *New Outlook for the Blind*, October 1954, Marianne J. Wolman, teacher at the school, tells of the school's experience in an article, "Interpreting the Needs of the 'Special Child' to the Parents and Children of 'Normal' Group." Parents of the school's "normal" children, who have good relationships with their own children, show little concern at the presence of the "special children," says she. On the other hand, mothers who are anxious, tense, and worried about their children are more likely to reject the children who are different.

To prevent delinquency

An Indianapolis community-guidance project which endeavors to reach children in trouble before they become hardened juvenile delinquents is described in the *NEA Journal* for October 1954. In "Reaching the Unreachables" Irma W. Cook, principal of Public School No. 7, Indianapolis, reports that the project, which is located in an underprivileged area, had made worthwhile progress in the 3 years it has been in operation and has achieved a high rate of success in the solution of immediate problems. Sponsored by the elementary schools and a community center the project is coordinated by a clergyman who is a codirector of the community center and trained in social work. "We do not say that our plan will work in your underprivileged areas," says Mrs. Cook, "but we do know that if you have the will, ways can be developed and adapted."

Families have feelings

"Understand Those Feelings" urges an article in the October 1954 issue of *The Crippled Child*. Its author, Eugene T. McDonald, director of the Speech and Hearing Clinic, Pennsylvania State College, is referring to the feelings of families of handicapped children, whose members often develop psychological problems in reaction to the child's handicap. These problems must be given attention if the family unit is to be fully rehabilitated, the author maintains.

Humility in parent education

A large store of valid child-care knowledge exists which can be passed on when parent educators have the "courage and honesty" to examine their own limited though important position in the picture, says Hilde Bruch, associate in psychiatry, College of Physicians and Surgeons, Columbia University, in the *American Journal of Orthopsychiatry* for October 1954. In an article, "Parent Education or the Illusion of Omnipotence," Dr. Bruch warns that there is danger of the whole parent-education movement becoming "discredited and repudiated as harmful" because of "basic errors" in the operation of the parent-education movement at the present time. To avoid that, she advocates more humility on the part of the expert, including "honest respect and sympathy" for his pupils. Only when such humility has been achieved can the parent educator be of real help to parents in psychological child care, the author maintains.

Support in childbirth

The shift from home to hospital for obstetrical care undoubtedly has resulted in untold benefit in safety to mother and child but with the change have come certain questionable practices, according to Hubert Thoms, M. D., and Ernestine Wiedenbach, M. A., R. N., writing in the *Journal of the American Medical Association* for September 4, 1954. They identify such practices as: separation of mother and baby; inability of husband to be with wife during labor; lack of privacy in general labor room; use of heavy sedation which blots out most of the mother's memory of her childbirth experience. In their article, "Support During Labor, Outline of Practice and Summary of Results from Mother's Viewpoint," the authors tell of a program at the Yale University teaching service which gives planned and integrated support during labor and delivery, and recommend that such a program be made a part of all labor and delivery-room practice.

Values and learning

"One cannot teach more than he is!" Hence: "If educational values are to be guides to sound planning and wholesome living with boys and girls, it is absolutely necessary that the teacher be capable of bringing the fruits of his own enriched personal living and reasoned philosophy of life to the planning-living activities of the highest type of school situation."

Teeing off from this concept, Harold G. Shane, professor of elementary education, Northwestern University, in an article, "Planning with Children," in *Childhood Education* for October 1954, suggests criteria for gaging educational values and devices for determining what changes in a child's values are desirable.

Music for palsied children

In the *Cerebral Palsy Review* for October 1954, Vally Weigl, music specialist at the New York Psychiatric Institute and the Cerebral Palsy Unit at Public School 85, New York, discusses the value of music as a therapy in working with children with cerebral palsy. In an article entitled "Music as an Adjunctive Therapy in the Training of Children with Cerebral Palsy," he reports that a musical stimulus can at times carry palsied children over seemingly insurmountable hurdles. Not only has music helped such children to relax, the author says, but it "has served constructively as an adjunctive aid in stimulating activity, strengthening muscles and improving motor coordination."

Interviewing adoptive parents

Although the giving of information to prospective adoptive parents regarding the child and his family background is often one of the less well thought-out aspects of the adoptive process, the way this history-giving interview is conducted at the time of placement may set the stage for the future, Lela B. Costin maintains in *Social Casework* for November 1954. In an article, "The History-Giving Interview in Adoption Procedures," Mrs. Costin, who is regional child-welfare supervisor, Illinois Department of Public Welfare, Champaign, Ill., discusses a number of principles which should be kept in mind "if the interview is to be constructive."

Integrated courses for nurses

Boston University School of Nursing has combined three former departments—maternity, orthopedic, and pediatric nursing—into a new maternal and child-health-nursing department which offers courses in child growth and development, play and recreation, field study of child behavior, and seminars in maternal and child-health nursing—core subjects that are considered the common base from which students begin their specialization. This development in nursing instruction is described in the *American Journal of Nursing* for September 1954 by three faculty members: Elizabeth J. Hall, professor of nursing; Rose Godbout, assistant professor of nursing; and Barbara Moulton, instructor in pediatric nursing.

Casework in child placement

When a child has been placed in foster care, ties with his family are still strong and both he and his family require the same diagnostic understanding and planned casework treatment as do families in other settings, Esther Glickman says in "Treatment of the Child and His Family After Placement" in the September 1954 issue of *Social Service Review.* The article points out that "total evaluation of strengths and pathology in the parents, the child, and the parent-child relationship should be the basis of establishing goals and of efforts to achieve them."

Changes in social security

The major changes in the old-age and survivors insurance and public assistance programs brought about by the recent Social Security Act amendments are described in an article, "Social Security Act Amendments of 1954: A Summary and Legislative History," which takes up 14 pages of the *Social Security Bulletin* for September 1954.

The authors are all members of the Social Security Administration staff: Wilbur J. Cohen, director of the division of research and statistics, Office of the Commissioner; Robert M. Ball, deputy director, Bureau of Old Age and Survivors Insurance; and Robert J. Myers, chief actuary.

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Page 25, *left*, University of Michigan News Service.

READERS EXCHANGE

(Continued from page 4)

increasing concern to the State and local agencies administering this program. Some of the difficulties encountered arise from the fact that while ADC is a federally aided public-assistance category, it is also a child-welfare program, and the prevailing pattern of separating the two introduces complications in adjusting services to the realities of individual family situations.

The joint approach to this problem by the Bureau of Public Assistance and the Children's Bureau is an encouraging example of imaginative and constructive leadership in a situation where such leadership is urgently needed. The work of the interbureau committee, as reported by Helen B. Foster and Annie Lee Sandusky ("Services in the ADC Program," CHILDREN, vol. 1, no. 6), raises a hope that many of the needed improvements can be achieved. Their report is a closely reasoned underpinning for services in ADC, which will undoubtedly be of great help to those concerned with program planning and interpretation to the public and to legislatures.

There is encouragement also to be found in the committee's recognition of the potentialities of untrained workers. This has meaning, however, only in reference to its next point concerning staff development and professional supervision. While this may sound like a bland observation, a little simple arithmetic will suggest the far-reaching implications of efforts to assign professionally trained and experienced supervisors for all ADC caseworkers.

Harold Hagen,
Child Welfare Consultant, American Public Welfare Association

CAPLAN: Eliminating the experts

Dr. Gerald Caplan has demonstrated in his work described in CHILDREN ("Preparation for Healthy Parenthood," vol. 1, no. 5) and through his previous studies that a number of emotional difficulties, most convincingly shown in guilt feelings during pregnancy, can be elicited and modified in a much briefer period of time than previously thought feasible. He has utilized such knowledge in an effective way through an organized team of workers in a prenatal clinic. I assume that the object of all such methods when applied to large numbers of people is to pass on the knowledge obtained to the physicians and nurses who work directly with them, and also to learn how to apply this knowledge under the limitations of the time and training of the personnel. In other words the problem is to integrate the knowledge into the routine service of the clinic and eventually make the psychiatrist and social worker superfluous for the majority of cases.

The difficulty that may arise when special experts are utilized in the experimental stage is that they come to be thought of as indispensable, permanent members of the program. After every public-health survey in which psychiatrists, social workers, and psychologists have been employed the typical recommendation has been the addition of more experts, more clinics, and more services. I hope that Dr. Caplan will not stop at the present stage in the development of his plan, however beneficial it may be, if it is found, and I hope it will be, that the method can be applied to large numbers in prenatal clinics the country over without specialized personnel.

David M. Levy, M. D.,
New York.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

REPORT OF THE EAST COAST MIGRANT CONFERENCE. May 17, 18, 19, 1954, Washington, D. C. Department of Health, Education, and Welfare. 1954. 110 pp. A limited number of copies available without charge. Address Paul Blackwood, Room 3280, Department of Health, Education, and Welfare, Washington 25, D. C.

This is a detailed report of a 3-day conference to work out steps toward improving health, education, and welfare services for families of migratory agricultural laborers in 10 States on the East Coast. A shorter account of this conference appeared in CHILDREN, July-August 1954.

REPORT ON THE NATIONAL CONFERENCE ON JUVENILE DELINQUENCY: held June 28–30, 1954, in Washington, D. C.; called by the Secretary of Health, Education, and Welfare; conducted with the assistance of the Children's Bureau and the Special Juvenile Delinquency Project. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1954. 77 pp. 25 cents.

This is the complete report of the Secretary's Conference on Juvenile Delinquency, a shorter account of which appeared in CHILDREN, September-October 1954.

PARENTS AND DELINQUENCY; a report of a conference. Edited by Helen L. Witmer. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. 349. 1954. 43 pp. 20 cents.

This report gives the gist of a 3-day discussion between members of the Children's Bureau staff and 15 psychiatrists, psychologists, sociologists, and social workers. A shorter version was published in CHILDREN, July-August 1954.

SCREENING SCHOOL CHILDREN FOR VISUAL DEFECTS; report of a study conducted in St. Louis, Mo., 1948–49. Marian M. Crane, M. D.; Franklin M. Foote, M. D.; Richard G. Scobee, M. D.; and Earl L. Green, Ph. D.; with statistical assistance of Bronson, Price, Ph. D. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. 345. 1954. 92 pp. 35 cents.

In the study described in this report each of more than 1,200 pupils was given a complete eye examination by an ophthalmologist and was also tested by a number of vision-screening procedures. The efficiency of each screening procedure was evaluated by comparing its results with the results of the ophthalmologist's examinations.

THE YOUTH YOU SUPERVISE. Department of Labor, Bureau of Labor Standards. Bull. 174. 1954. 14 pp. 10 cents. A limited number of copies available from the Bureau of Labor Standards without charge.

This pamphlet was prepared with the advice of the Bureau of Labor Standards' Technical Committee on Supervision of Young Workers, which represents a number of fields such as adolescent psychology, industry, organized labor, labor-management relations, and education. It is addressed to supervisors of the nearly 7 million teen-agers at work in the United States, and explains how youngsters grow, how they think and learn, how they feel, and what they want.

It suggests ways in which a supervisor can help young workers develop good attitudes toward the job, plan and organize the work to be more suitable for them, show them how to carry it out, and help keep them healthy and free from accidents.

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frontispiece

WITH ABSORPTION and wonder this child of the United States mainland seeks an answer to the mystery of growth—an inquiry that has occupied scientists for centuries.

In Puerto Rico this natural urge to dig and plant is fostered by the schools which are integrating a school gardening program with an Island-wide effort toward nutrition improvement. [See page 65.]

—Photo by Philip Bonn

A one-man example of the "interdisciplinary approach," Dr. Marvin K. Opler has for the past 20 years engaged in research and teaching in the related sciences of anthropology, sociology and psychiatry. Before taking up his present position, he had been chairman of the anthropology and sociology departments of Reed and Occidental Colleges in Oregon and professor of anthropology at three universities—Stanford, Harvard, and Tulane. He began his psychiatric studies at the Morningside Clinic and Hospital in Portland, Oreg., a Federal psychiatric hospital for Indians.

A graduate of Simmons College School of Social Work, Katharine L. Foster began her career in a family-service agency but soon switched to medical social work, a field that has absorbed her attention for the past 25 years. A large portion of these were spent in the social-service department of the Massachusetts General Hospital and with the American Red Cross which sent her to Germany to work in an Army neuropsychiatric hospital. Miss Foster has been in her present position for the past five years.

On her return from Iraq, where she directed the maternal and child health center described in this issue, Dr. Elizabeth Peabody Trevett became medical director of the Children's Bureau staff in Region IV, with headquarters in Atlanta. Before going to the Near East, Dr. Trevett was engaged in the private practice of pediatrics in Annapolis, Md., and was also serving as consultant in pediatric clinics in two Maryland counties. She had previously worked with Dr. Helen Taussig at Johns Hopkins University studying cardiac conditions in children and with Dr. Harold Stuart in his growth and development studies at Harvard.

Before becoming director of Puerto Rico's newly established Bureau of Nutrition and Dietetics in 1951, Esther Seijo de Zayas was for 12 years on the staff of the Extension Service, U. S. Department of Agriculture, in Puerto Rico. For ten of these she served as both food and nutrition specialist and as assistant director in charge of home-demonstration work. Having taken her undergraduate work in education from the University of Puerto Rico, she taught home economics in the schools before getting both an M. S. and a Ph. D. degree from the University of Chicago.

A combination social worker, writer and editor, Marion Robinson is a graduate of the New York School of Social Work. Before World War II she did casework in a family agency in Baltimore. In 1941 she joined the USO program, serving in an editorial capacity first through the National Board of the YWCA and later at USO headquarters. Subsequently, she was associate editor of the *Survey Midmonthly* for 4 years before becoming a free-lance writer in 1949. Since the beginning of the St. Paul study she has worked closely with Community Research Associates.

READERS' EXCHANGE

SHANNON: An Emotional Journey

At recent meetings of the International Association for Child Psychiatry the problem of helping parents adapt to the stress of the birth of a child with a congenital anomaly was cited as a major goal in programs of preventive psychiatry. In the light of these discussions the important contribution on this subject by Victoria Shannon is especially to be welcomed. ("When Children are Born With Defects," CHILDREN, January-February 1955.)

Apart from noting the technical complexity of the problems involved this article draws attention to the special emotional burdens which they present to the professional people who face the task of helping the parents. It is probably because of our own subjective difficulties in this situation that we have in the past largely neglected to deal with a difficulty which affects as many as 1 to 2 percent of all births.

The crucial stage occurs in the lying-in period and because the mother usually leaves the hospital in about a week to go to the care of a new set of professional workers it is easy for the problem to be shelved so that the "unpleasantness" can be handled elsewhere. Rationalizations such as "the sparing of the mother's feelings" come easily, and interdisciplinary difficulties of communication make matters worse.

What is missing in the article is some suggestion for systematically dealing with the subjective difficulties of the workers in the lying-in hospital. I feel that any program to improve our care in these cases must solve this central problem if it is to lead to a practical result.

Of course the problem of the adaptation of the parents to the blow does not end in the lying-in hospital, and I am glad the symposium repeatedly stressed that such adaptation comes as a result of a mental process which takes quite a long time. It is helpful to conceive of the model of an emotional journey which takes time and work to accomplish. As caretaking agents of the community our job is not done when we set the parents on the right road; we must stand by to help them time and again as they reach new obstacles, and we must get to know them so as not to force the pace beyond their capacity.

Gerald Caplan, M. D.
Division of Mental Health
Harvard University School of Public Health

The Nurse's Role

While there is no one magic formula for helping parents faced with the problems that arise when they have a child born with a defect, Victoria Shannon's article shows ways in which a team with wisdom, vision, work, and time may assist them. However, it would have been more helpful if it had defined not only the roles of each member of the team but also ways of managing their overlapping.

The social worker's role as described by Mrs. Shannon is one that many nurses have always considered a description of good nursing care. The role of the nurse is defined in the article in a too narrow sense.

Who else but a nurse in such a crisis situation can better provide an informal, friendly, and comforting approach? Who else but the public-health nurse knows so much about the home, neighborhood, and community situation, or about the other people who may be present in the home such as boarders or relatives? All or one of these factors may be interfering with the parents' attitudes and possible acceptance of their defective child.

In spite of this shortcoming Mrs. Shannon's sensitivity to the need for all the team, as well as the parents, to have good concrete information on the steps to be taken to help the child is a refreshingly mature approach.

Fannie T. Warncke, R. N.
Director, Public Health Nursing,
Department of Public Health,
Oakland, Calif.

Where No Specialists Exist

The interprofessional panel described by Mrs. Shannon has emphasized important areas of consideration for professional workers.

Some areas she does not mention also need consideration by the team: 1) helping the parents to enjoy their baby as a baby though born with a defect and 2) projecting a tentative plan in relation to follow-up care and education. So often parents ask "Will he be normal? Can he go to school?" They need reassurance but within the limits of the child's disability so that they will not become unduly optimistic and so lose confidence in the professional team.

In geographical areas where there are no "specialists," the family physician and the hospital and public-health nurses will have to carry on the services to the families in which there is a child with a congenital defect. The knowledge, skill, and insight outlined by Mrs. Shannon must be acquired by this smaller team and integrated within their daily contacts with these families.

Anne L. Twomey
Mental Health Consultant, Visiting Nurse Association of Boston

Help for the Father

As the interprofessional panel described by Mrs. Shannon has pointed out, the birth of an abnormal child creates many problems for parents and those responsible for helping them. Placing responsibility on one parent alone is a pitfall into which we as professional people can tumble as we see the father as the able-bodied member of the parental pair.

I was particularly interested in the pediatrician's reference to the question of placing the whole burden of prebirth knowledge of a defect on the father alone. When the defect is not found until after the birth of the child the father is often the first to know of it, and so carries the burden alone for a few hours—sometimes a few days—until some decision is reached about the possibilities of medical care and the appropriate time to tell the mother. The father is not afforded the protection which the hospital environment temporarily gives the mother and has little time to come to terms with his feelings before he returns to his home and work environment where inquiries will be made and explanations and answers must be given.

It has been my observation that the father needs and wants the immediate help of the professional team and that it is as essential for the team's activity with him to be coordinated as the activity with the mother.

Mary Jean Clark
Senior Social Worker, Chicago Lying in Hospital, University of Chicago Clinics

KELMAN: Institutions Needed

In his extraordinarily solid and comprehensive treatment of a complex subject too often approached piecemeal, Howard R. Kelman quite rightly emphasizes facilities and services for mentally retarded children out in the community. ("A Program for Mentally Retarded Children," CHILDREN, January-February 1955.) But I am afraid that the current trend to "keep them at home" may lead to almost as much of an extreme as the old, unlamented, universal "put them away." Improved residential care is not even listed among the "Steps Ahead."

Yet residential care can have positive values, not only for severely retarded children, but also for those near enough normal to suffer from their ineptitudes and differences from their contemporaries. Often a few years' life and training in the nonfrustrating, noncompetitive world of an institution may give a child the emotional peace and confidence which enable him to go out and hold his own. Sometimes a child who would have to return to a complex environment may not only be happier but also more productive as a long-term resident in a place geared to his capacities.

What's more, the State school ideally could be a center of enlightenment. It contains a gold mine for medical research. It could develop teaching methods. With its 24-hour continuity and potential for a "total push" program, it could demonstrate all that can and cannot be done.

Edith M. Stern
Silver Spring, Md.

More Vocational Guidance

An unusual circumstance heightened my interest in reading Mr. Howard Kelman's article, "A Program for Mentally Retarded Children," for I had just engaged the author as consultant in community services for the National Association for Retarded Children. Would the article reveal some discrepancies in my own and Mr. Kelman's points of view of which I was not aware?

Actually the only difference was in emphasis, for I feel that the article did not sufficiently stress vocational guidance and placement of the mentally retarded in competitive employment.

Advances since the turn of the century, and especially since the last World War have shown us that many more of the retarded could be taught to be self-supporting and productive citizens than we formerly believed. I ascribe this trend partly to constructive changes in attitude by professional workers, perhaps more to improved methods of assisting the retarded and their families and the external influence of a changing economy with wider availability of jobs, and to a much lesser, but real, extent to changes in social attitude toward the handicapped in general.

Some social workers and physicians stress sheltered employment as the goal. Educators and psychologists stress occupational preparation. Why? There is a selective factor operating, and generalizations are hazardous in view of the wide range of differences among the vast numbers of mentally retarded.

Salvatore G. DiMichael
Executive Director, National Association for Retarded Children

REDL: Newspapers Maligned

I was very much interested to read Dr. Redl's comment about newspapers in his article "Our Troubles With Defiant Youth" (CHILDREN, January–February 1955.) I refer specifically to the paragraph on page 6 in which he expressed the view that newspapers generally imply that a juvenile delinquent is "typical" of the youth of our time and in which he questions whether newspapers ever "write up as a typical teenage deed" the heroism of an Eagle Scout.

Dr. Redl's remarks can constitute a smear against newspapers. Can he cite one instance where a newspaper has implied that delinquency is "typical of the youth of our time"? Has he made a study of one or more newspapers to analyze the content to compare the reporting of good deeds of teen-agers with the reports on juvenile delinquency?

It may interest you to know that the publisher of the San Rafael (Calif.) Independent-Journal made a careful analysis of his newspaper on this subject and published the result in an editorial December 7, 1954, quoting all of the headlines in one issue of the newspaper relating to youth. There was a tremendous preponderance of stories about worthwhile youth activity.

Cranston Williams
General Manager, American Newspaper Publishers Association

JOHNSTONE: On the Gellhorn Report

Professor Johnstone's review of *Children and Families in the Courts of New York City*, by Walter Gellhorn and associates, complains that the report is vague about changes in divorce and annulment procedure. Insofar as independent court investigations in custody and support matters are concerned, the study definitely recommends them. Judge Paul Alexander's experience in Toledo indicates that such court investigations do not have any adverse affect upon lawyers' practice in matrimonial matters.

The report did not, however, reach a definite conclusion on the issue of mandatory marriage counseling. Reference is made to the danger that counseling might become a mere formality if it were made compulsory in all cases. And the report expressed doubt as to whether adequate standards were at present available to implement judicial power to grant or withhold a divorce simply on a finding that the marriage was or was not viable.

It may be that some valuable experience in the development of workable standards will emerge from the recent plunge of the California courts into the issue of whether "the legitimate objects of matrimony have been destroyed." This is the newly formulated basis for the exercise of the trial court's discretion in applying the defense of recrimination. *Phillips* v. *Phillips*, 41 Cal. 2d 869, 264 P. 2d 926, well discussed in Note, 42 Calif. L. Rev. 519 (1954). Unfortunately the California courts, in embarking upon this experiment, are not provided with adequate professional staff to investigate and to advise them about the crucial psychological factors involved.

If the experience here fails to produce effective guidance for judicial administration of broad standards, perhaps it will become necessary to explore Mr. Johnstone's suggestion that fact-finding power in this area be lodged in qualified administrative boards. One

(Continued on page 80)

CULTURAL VALUES AND ATTITUDES ON CHILD CARE

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TWENTY YEARS AGO Ruth Benedict described children as "the little creatures of their culture." While in the past 20 years anthropologists have come to recognize the great diversity of personality within any one culture, the fact remains that child-care practices as well as the behavior of both children and adults are strongly determined by the culture and the times.

In this country the growing body of knowledge on both mental and physical hygiene has dictated the child-care methods advocated by the social and health agencies that serve children and their families. But the zeal for improving health and welfare of American children has sometimes overshadowed the recognition of diversity in values in a country which encompasses not one but many cultures. Too often failures that have been chalked up to stubbornness or ignorance on the part of the objects of services have actually stemmed from blindness to diversity in value systems on the part of those attempting to serve. Success is more likely to come with an intimate knowledge on the part of professional persons of the ways and ideas of each group within our culture and of the groups within groups, and with the kind of imagination that can make use of this knowledge.

Among the most important of these groups numerically are the American Indians (containing a number of distinct and separate cultures), Japanese, Chinese, Europeans from a variety of nations, Mexicans, and Puerto Ricans. Each of these groups has its traditional method of child care which is inextricably linked not only with its traditions and customs but with its system of values—the degree to which a child respects its elders, accepted attitudes toward sex play and the relationship of the sexes, the relative importance of individual and group.

In the past, a recognition of pattern in the customs and behavior of various peoples, tribes, or nations led many anthropologists to believe that culture patterns were psychological in essence—that psychological principles determined the selection, over a period of time, of the form and content of the culture itself. Unfortunately simplifications of Freudian theory led to the assumption that the basic infantile disciplines could explain the complexities of a cultural way of life. In *Patterns of Culture*,[1] Ruth Benedict seemed to imply that whole cultures of peoples were obsessive or paranoid, or torn by hostile aggression. Another author found the religion, social life, and customs of the Balinese, affected by emotional outbursts in dissociated forms, attributable to the indirect casualness and emotional rejection or neglect with which they are treated as children.

Similarly several middle-European Slavic peoples were described as being variously defective in adult behavior to the degree to which they had been swaddled in infancy. Japanese and Japanese-American passivity was attributed to rigid toilet training and emotional constriction in their earliest home environment. From one clinical model to the next, fragmentary aspects of child-rearing practices were proclaimed to be *the key* to any culture and its problems.

In the past few years, however, preoccupation with infant disciplines such as weaning and toilet training has given way to more inclusive views of child-rearing practices, and even these have come to be regarded as illuminations for a general comprehension of cultural differences, rather than as causative factors. Today, practically no anthropologist believes culture *moulds* children directly into fixed, invariable patterns of behavior. Most anthropologists agree that method of child care is only one of a series of significant variations among cultures. They now recognize that culture, as an elaborate and perhaps the chief adaptive mechanism of whole groups of people, embodies a great range of unconsciously learned, patterned, and traditional behavior. While variables in experience or motivation operate in individuals, each person still uses the norm or value of his cultural group for measuring the differences.

In actual living and in family functioning, the totality of adaptive mechanisms is called into play. A person's cultural background is thus both in his individual personality, and in certain shared attitudes, customs, and behavior patterns. It is therefore both past and present, parental and individual, learned and motivated, rational and emotional.

American Indians

The various tribes of American Indians have widely different cultures, but whether infant disciplines can explain the different tribal characteristics can be questioned. E. H. Erikson, psychologist and psychoanalyst, has attempted in *Childhood and Society*,[2] to relate aboriginal Sioux hostility and bravado in Plains Indian warfare to—among other matters—the stored-up restrictions of the Indian cradleboard, and of the sudden interruption of long periods of nursing when mothers become irritated by the babies' biting with newly erupted teeth. However, my own studies have revealed that among the more peaceful Utes, babies nurse even longer than among the Sioux, and a mother or her sister or cousin may sometimes continue the suckling to the age of four, long after the baby's milk teeth have erupted. The Ute culture is distinct from the Sioux.[3]

Among the Utes, most ceremonies are intended to promote health, vigor, and beauty, and involve children or young adults. The infancy ceremonies attain for children protective supernatural power, to which they later add for themselves, through dreams or sun-dance participation, increased religious rapport or personal supernatural power. There is no tendency toward dual standards as among Plains peoples. While the Utes prize family solidarity, they practice trial marriages up to the birth of the child or the decision to hold a marriage ceremony. Even thereafter marriages may be broken by mutual consent or the firm decision of either spouse.

Health-vigor and *freedom-from-worry-or-threat* are two Ute words connoting "good" or "happy." Throughout the family and relationship system individuality is subordinated to age and authority for the general good, but within this larger set of values, children are indulged, protected, and trained. At the birth of a child, a complicated 4-day ceremony requires a father to undergo ritual lying-in, and then to take part in a ceremonial hunt and infancy ceremonies designed to bring long life, successful hunting, and good health to all family members. On one reservation when this custom, the *couvade*, and its taboo against males who are not members of the family being present in a birth camp were ignored by a governmental order requiring hospital deliveries, the Ute male patients, in all stages of all illnesses, gathered their blankets about them and left the hospital.

On the other hand, the Apache Indians of New Mexico, who also emphasize solidarity of family members in an extended pattern of relationship, including cousins, do not divide authority equally between men and women, nor do they venerate age. Adulterous women or jealous wives may have their noses slit and ears notched by irate husbands. While confinement for delivery requires women to be separated from males, as does menstruation, birth is less ceremonious and affords the family nothing like the protective atmosphere it does among the Utes.

Apache children grow up in stricter and less indulgent families than the Utes. Their training emphasizes hardening for males and vigor and industry for females. Among these once warlike people the grandparents frequently have warmer and closer relationships with children. However, residence of the married pair is always close to the girl's parents, and a series of formal restrictions, including polite avoidance and a special respect language, are imposed upon sons-in-law. Thus principles of rigid formality are introduced into the family scenes, complicating the control and training of the child. Weaning among Apaches comes earlier and children are seldom indulged.

The Navaho Indians to the southwest of the Utes, in Arizona, have tended to centralize the religious rites of singing and curing into a few trained hands. Yet while they consolidate religious authority, they diffuse parental control in an extended kinship pattern which adheres more closely to the matrilineal local group than the Ute or Apache patterns. At the same time the Navahos handle infants and children permissively, allowing much retention of individuality, personal freedom, or spontaneity. Projective-test materials from Navahos show considerable individualism and a lack of emotional constriction.

The Hopi, settled agricultural relatives of the Utes, have a still broader sense of community solidarity, involving obligations to clan or matrilineal line which override individual and even family autonomy. A people who pray through fixed, calendrical, and group-connected rituals, who have priesthoods, who plant and wait, or even dance with inexorable and patient insistence, they have less need for immediacy or for direct, individualized expression of thought, action, or emotion. With them individuality and personal freedom are frowned upon as evil, and are subordinated to the well-worn grooves of a traditional security. The Hopi child is taught to refer all thought, emotion, and impulse to pervasive group standards.

Behind the dignified restraint of most Chinese-Americans lies a warm love of children—obvious in the expression on the face of this New York father as he looks at his son.

Japanese-Americans

Most subcultural populations in the United States seem to be composed of people having a cultural stock-in-trade. Whether family-oriented or community-minded, they are consciously or unconsciously adherents of some culturally definable tradition which influences deeply their expressive life, their emotional economy, their moral standards, and their health practices.

We often ignore these facts in times of emotional tensions. Who cannot remember our wartime notions of Japanese-Americans as being a "race," as being unemotional and superficially insincere?

The Japanese-Americans' curious efficiency, reticence, or dignity and restraint in extrafamilial surroundings is not due to "race." Among them, as in other groups, individual variations in character and temperament abound, though they do exhibit central tendencies in behavior. Certainly these last are related to the way their children are "raised." However, their child-care goal is not emotional constriction, as some writers have alleged. Children are restrained in school, but are wholeheartedly spontaneous and indulged in the home. This is particularly true in regard to eldest sons, and to lone children whether girls or boys. Schooling, however, is very formal and teachers are revered.

The hope in Japanese families that the revered elder males of the family may retire at 60 is not always met in fact, but the prevalent desire is for a son to become established early in life so that he might eventually be a source of support. While a single daughter can continue the family name, through *yoshi*-marriage (the binding of a son-in-law through adoption, with assumption of the family name) there is a general system of male supremacy and parental authority. Japanese girls are subordinated.

This inflexibility of the Japanese family system and customs is understandable in the light of the poor and rigidly feudal economy in which it was born.

In the Japanese island kingdom, forest floors are actually brushed clean for charcoal and brushwood. Of three frugal meals customary in the villages only one is ever cooked. Industriousness, restraint, and self-discipline are universally prized. Yet in spite of some subservience remaining from the recent feudalism there is striving for position. The emotional restriction Geoffrey Gorer in his *Themes in Japanese Culture* [4] hypothesized as the result of rigid toilet training, and Ruth Benedict reported as arising from constriction of childhood activity in the home [5] is simply not there in fact. F. S. Hulse and others have documented Japanese resistances to authority in wartime Japan.[6] The rate of absenteeism in industry rose to between 40 and 50 percent from a normal of 10 or 15.

There are abundant data, as well as the evidence in such films as "Gate of Hell" or "Ugetzu," or Lady Murasaki's great novel, *The Tale of Genji*, to document the Japanese capacity for emotional outburst and their poignant and touching regard for women and children. Evidences of the solidarity of the family and of striking social community-mindedness among the Japanese are also not difficult to find.

The noticeable placidity in Japanese children is derived from values based on an economy of restraint and of efficient order also visible in Japanese art and architecture. What may seem to us as a rather tragic soberness and singleness of purpose is not a dead stamp upon woefully constricted character and temperament but behavior arising from traditions and values different from our own.

Cultures in Transition

When a people moves into a setting dominated by another culture or by conditions requiring immediate adaptation, values may be challenged and a child become subjected to a confused cultural heritage. Such cultures in transition are not new in the American scene nor are they only a part of history. Today one of the largest groups subjected to abrupt and unsettling change are the Puerto Ricans who in the hundreds of thousands have come from their island home to the American mainland since World War II. For too many their customs have become a confused hodgepodge of old and new.

In New York an infant of Puerto Rican parentage is born at home more usually than in a hospital and kept in close proximity to the mother. (In Puerto Rico babies are kept in a hammock in easy reach of the parental bed.) But in contrast to the practice on the island weaning may come abruptly when the mother finds employment, for she is apt to have better job opportunities in the garment industry than her husband does in the service trades. There is no question about the Puerto Ricans' great cherishing of children, but the economic necessity which takes women from the home scene induces a series of changes challenging long-standing values.

Puerto Rican children such as these are now a familiar sight in New York City. The economic pressure which sends mothers to work is breaking down the customary child care patterns among families who have migrated from Puerto Rico.

The Puerto Ricans' Spanish, father-authoritarian culture requires fathers to rule the home, to be fed with male guests before women and children, and to conceive of donations to the household as enhancements of their own reputation as providers. On the island a strict double standard, consistent with this patriarchy, governs the regulation of sexual conduct in which, again, the male is expected to be dominating and demanding, the female modest and shy. As frequently happens where values and economics clash headlong, many Puerto Rican fathers in New York have difficulty maintaining a tenuous authority and singlehandedly supporting a home. The newly found freedom and importance of women sometimes leads to a series of common-law liaisons, for the male loses his status with his role of provider. Many men react with hypochondriacal complaints and fears of impotency, while children compensate for the absence of their fathers by clinging to their mothers.

In two large day-care centers in Yorkville, a New

York City neighborhood, the author recently conducted a behavior study of children, reaching back into the home. That the children's behavior problems stemmed from the home scene and its stresses and strains certainly is not news to health and welfare workers. In these instances, however, the "home problems" often proved to be problems of cultural conflict. For instance, many Puerto Rican boys were up against the shambles that life in New York had made of their parents' cultural values. Or if their homes had remained intact their parents, worrying about the neighbor children's lack of respect towards their elders, had become overstrict or overprotective.

Cultural conflicts were not restricted to one cultural group in Yorkville. German-American mothers and grandmothers were often troubled about what they termed the general laxness of "discipline" or the great encouragement of spontaneity in the nursery-school programs. They tried to balance this by increasing rigidity at home, although their efforts were instigated less by provocation from the child than by paternal demands for greater obedience. With several children the schism between home and school had led to behavior problems in the school because they could not risk acting out their feelings at home. This behavior was also disconcerting to the parents, as their standards of child conduct were as exacting for school as they were at home.

Irish mothers in the same neighborhood worried less about discipline. The authority of school had a kind of official, sanctifying glow about it, and was granted to be supplementary to the authority of the home. Yet the center's summer practice of having the children take showers in the nude without separating the sexes, no problem to the German mothers, was positively frightening to some of the Irish-American women. It conflicted with their personal and cultural attitudes and ideas about nudity, sin, and sex, for which they had not prepared their children.

While some German and Czech mothers approved of both the showers and the sunbathing which preceded it as good "physical culture," Slovakian mothers, from patriarchal rural backgrounds, approved of the exercise involved but frowned on the nudity, especially among the girls. Czechs, from a more strongly matriarchal culture, argued that what was good for boys was good for girls too, although they tended to worry about the general lack of discipline for children. On the other hand, Italian mothers in the group assumed that boys were less amenable to control than girls, and girls required more protection. They were most receptive to notions about expressive spontaneity.

Implications for Practice

In any setting, alertness to such differences makes it possible to find ways of using them to the advantage of the individual. Ignoring them may bring real trouble.

Clyde Kluckhohn, in *Mirror for Man*,[7] has carried culture analysis into program and planning areas. He points out that once recognized and properly assessed these cultural differences—the points of cleavage built up from underlying values and attitudes—become the basis for achieving rapport in interpersonal contact and communication. Man, he maintains, can anticipate, prepare, and in some measure, control behavior "to the extent that human beings discover the nature of the cultural process."

Problems of prediction and control are the very essence of the applied social sciences. To prevent delinquency or "broken families" we must discover the meanings behind the behavior of young people, as well as the ingredients of successful marriages and families, and of good health. We must recognize not only the official or agency definitions of such terms, but also the individual and cultural definitions which may vary at points. Our own ideas of healthy conduct may require all children to retire long before adults, while others, like people from South Italy, regard children as such an integral part of family life that they are expected to rise and sleep on the schedule of their elders and to be included in all family events. We may be urging expectant mothers to reduce the starch in their diet at the same time that their mothers are encouraging them in the belief that only *pasta*, with red, blood-making vegetables and olive oil, can really build a large and healthy baby. We may ask them to take exercise, while their folklore forbids this as inducive to early parturition. Similarly we may be advising postadolescent boys to develop a portion of their leisure interests at home in the setting of the family, as their sisters are doing, without recognizing that the boy *and* his family agree that he, like his father, must have his own social life in male company if he is to be considered duly virile.

Those coping with practical problems will realize, if not by training then by bitter experience, that no amount of exhortation or allusion to the *science* of a program will magically transmute it into action against warmly felt family feelings. Programs only become understandable to individuals and groups when translated into individual and cultural terms. Since all cultures prize health, welfare, the family, and socially oriented conduct in *ultimate* ethical terms, programs become effective when acceptable ways of achieving these are presented. This is true even where individual resistances are operating. Certainly, protein-rich and low-starch *pasta* can be made to accompany the red vegetables; and compromises in infants' schedules can be allowed to accommodate special cultural events.

Leighton's *Governing of Men*[8] reviewed the experience of a governmental agency, the War Relocation Authority, charged with the custody and maintenance of Japanese-Americans removed to inland internment centers from the West Coast during World War II, and found that "stereotype-minded" administration failed to solve operational problems in community life which "people-minded" administration solved readily. I myself published similar conclusions as chief of a research staff charged with studying the Tule Lake Segregation Center, where 20,000 Japanese Americans ineligible for individual resettlement were congregated.

After careful study of Japanese-American values and attitudes, population demography, family organization, center associations, and administration we were able to predict such occurrences as the emergence of specific kinds of leadership, the refusal of thousands of families eligible to move out of the center to do so, general reactions to the health and welfare programs, and even an eruptive movement aimed at the center hospital. The hospital trouble arose from the administration's ignorance or disregard of special attitudes towards health and curing among the Japanese—their respect for folk methods of healing, their idea that pain must be stoically endured, especially in childbirth, and the operative procedures preferred by the Japanese surgeons. When the hospital separated a dying baby from its parents, accumulated resentments erupted into a demonstration of protest. All these values and attitudes, recorded in the daily life of the community, had pointed clearly to the coming of the eruption.

In Summary

Unless modified by travel, education and cross-cultural experience, we are all of us culture-bound in various degrees so far as emotion, motivation, or the learning process are concerned.

However, it is impossible to understand cultural characteristics merely by scrutinizing "infantile disciplines" or the modes of handling children. The social and cultural backgrounds which contain these disciplines and every aspect of the treatment of children will influence the individual throughout his life. This influence ranges from habits of speech and thought through customs and attitudes having to do with notions of duty and obligation, the role of the sexes, the means of worship, or the size and composition of the effective social units. Customs and attitudes, whether they relate to ideas of proper male and female conduct, notions of family authority or egalitarianism, emotional expression, or whatever, may evoke one type of situational response and make another unthinkable. They constitute the outlines of a motivational and expressive system larger than the individual but allow for individual styles of interpersonal contact, communication, and reaction to events.

For the past 3 decades studies in which psychiatrists and anthropologists have jointly participated have documented the social and cultural variables affecting human lives, and consequently mental health, and have presented data on childrearing in psychological *and* cultural dimensions, pointing to the strains imposed upon children arising from challenges to the cultural values of ethnic groups. Rather than explaining cultural ways as arising from methods of child care, they have related culture and personality variations, and in so doing, have found child-care methods to be an expression of culture.

As social and health agencies recognize this fact and find ways of working within the cultures of the people they are trying to serve, their goals will become more attainable.

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Experiences in a hospital school have revealed some . . .

STABILIZING INFLUENCES IN HELPING HANDICAPPED CHILDREN

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THE GREATEST ALLIES of persons dealing with the problems of handicapped children are the stabilizing factors that often exist within the child himself in his family or other personal relationships, or in outside circumstances. What these are and how they affect the child's progress have been amply demonstrated by the patient-students at the Massachusetts Hospital School for Crippled Children, a resident school for the orthopedically handicapped child of normal mentality, operated by the Massachusetts State Department of Public Health.

The Hospital School admits severely handicapped children whose disability prevents them from attending regular public school, whose medical treatment would interfere with continued schooling for a period of one or more years, or whose poor adjustment to their handicap has interfered with their progress in school. The patients range in age from 3 to 21 years, but a child of 3 or 4 is admitted only if the medical need seems to be so important that delay might constitute a threat to his life or hinder his progress by establishing fixed abnormal muscle patterns of position and function.

By orthopedic surgery, physical therapy, and occupational therapy the School helps the child to attain maximum power and efficiency within the limits of his physical disability, with the aim of returning the child to his own home and community as soon as possible.

Now that educators are giving increasing consideration to the exceptional child, the educational needs of the less severely handicapped child are being met more and more by regular school systems, thus enabling the Hospital School to transfer children to their community school after they have achieved certain goals. However, many patient-students with physical handicaps severe enough to preclude the possibility of their ever attending public school remain at the Hospital School for completion of academic and vocational training. Comprising the major portion of the enrollment they include children seriously disabled as a result of accidents or traumatic illnesses such as poliomyelitis; congenital conditions such as malformations, spina bifida, and cerebral palsy; or familial diseases such as muscular dystrophy. Of the institution's 131 patients, 72 are paraplegics, who because of paralysis are able to walk, if at all, only with braces and crutches, and often are incontinent of bowel and bladder.

The problems of helping children with such handicaps to a positively oriented existence are clearly evident. Everyone working with these children is aware of the negative aspects. Their seriousness cannot be denied, but it is possible also to point to positive factors with which and by which constructive goals can and have been reached.

Parental Support

Foremost among these factors may be the family's attitude. There was at the Hospital School a few years ago a severely handicapped boy with cerebral palsy who when he came at the age of 19 on referral from a treatment center had had no formal schooling and was completely dependent upon his family. He walked with a laborious, hitching gait, but he could get around fairly well with a large tricycle. His speech, always with grimaces, was unintelligible except to those who were with him constantly. His athetoid movements seemed to defeat any practical training. On the surface this boy, Frank, seemed to present an insoluble rehabilitation problem to the School.

The Hospital School's social worker visited Frank's home and learned from his mother that she had been following the treatment center's recommendation to encourage him toward as much independence as possible. Previously whenever Frank had gone out on his tricycle some member of the family had followed along after him. Though feeling almost desperate the mother had taken her courage firmly in hand and had allowed him to go alone, even when this evoked the criticism of her neighbors. She told of watching out the window while Frank worked at least half an hour by trial and error to unlock the padlock to the shed where his tricycle was kept. She spoke with pride of his persistence, thus exhibiting not only her courage but also her unconditional love and respect for her son. Other members of the family also showed their love for Frank by welcoming the social worker with enthusiasm when she visited.

Such warm backing from his family assured Frank's progress. Despite his athetoid movements, he continued the training in weaving he had started at the treatment center. He also managed to get as far as the sixth grade in his school lessons. Now he sells his weaving products in his home town, advertising them himself as he rides around on his tricycle with a placard in front and on back. Although his weaving does not bring him great financial returns Frank in a sense represents total rehabilitation, for he has learned to use his limited capacities to their fullest extent and has become an accepted member of his community.

Realizing the importance of maintaining the child's close relationship to his family, particularly with those children who must remain away from home many years, the Hospital School encourages visiting on both Saturdays and Sundays and gives liberal vacations to the patients, including a long summer vacation. But some parents cannot accept their children enough to take advantage of these opportunities.

We have known a number of children much less severely handicapped than Frank who have been totally rejected by their families. In such instances we try to help the members of the family toward more acceptance of the handicapped child by patience, sympathy, and understanding of their own needs. But what if we fail? Then we must rely on a situation which is perhaps characteristic of any inpatient institution, wherein a variety of persons know the children and have an opportunity to become somewhat of a parent substitute to one of them. Thus an attendant, a man on the farm, a housemother, a teacher, while not actually filling the place of a child's mother or father, may at least become a confidant, a special person in the youngster's eyes. Or we may, if we are very lucky, find someone outside the hospital environs who takes the child home on vacations "just like the other children."

Rejected Children

Although the grossly rejecting families are not many—currently 10 out of our total population of 131—their rejection is such a tragedy for the individual children involved that for the social worker it looms as a large and serious problem. The parent substitute helps to dilute this problem by providing a stabilizing factor for the child. Usually the close relationship involved has arisen spontaneously between the child and a member of the institution's personnel. Occasionally the social worker has taken an active part in fostering such a relationship, and has provided interpretation of the child's needs to the parent substitute and supportive help to both the parent substitute and the child. Sometimes the child may have been so badly hurt psychologically and need so much help in relating to another person that the parent substitute may have to be the social worker herself who may use her training and experience to help the youngster form a relationship which may provide him with a constructive experience.

One of the school's fairly recent graduates was a youngster who had been caught in an intolerable family situation. Even prior to the onset of her physical difficulty she had been the victim of rejection by a mother who did not want to be bothered with children, and had been placed in a foster home. Her parents were finally divorced and subsequently both were remarried.

The girl, Beth, was intelligent and attractive in appearance. She was wheelchair bound, but had good upper extremities. She was not disliked by others but neither was she popular, as she lacked warmth and was caustic in manner. Her way of meeting people's curiosity about her handicap was to glare at them. She never went home for vacations and was not invited by others, partly because of the severity of her handicap and partly, perhaps, because of her caustic attitude. During each vacation Beth came to the social worker's office and wept bitterly and uncontrollably.

Beth's mother visited perhaps twice a year with many promises which were never fulfilled. Therefore, the girl was alternately lifted up with hopes of her mother's love and interest, and let down to miserable suffering. After several years of this, and as Beth became older, the social worker felt that if the girl could understand her mother's inability to fulfill the role of a mother, her own hurt would be lessened. She tried to give her that understanding but at that time felt she had achieved little success.

During the following years the social worker and Beth discussed Beth's family situation; what went into making friendships; the advisability of accepting a person's curiosity regarding her handicap and of meeting new people at least half way; plans for the future; and various other topics. They began doing something together each vacation, for this was a time when Beth needed a parent substitute even more than a social worker. Sometimes they included Beth's younger sister who had also been rejected by her mother and lived in a foster home.

The constant support available to Beth when she needed to let her loneliness spill over during those years and later in the first critical weeks after she had left the protected environment of the Hospital School to take a job, enabled her to become a self-supporting, competent young lady. Last summer she was able to go on a vacation by herself to a place where she was the only girl with a physical handicap. She found that she was well liked, possibly because she no longer had to glare at the world, but was meeting it smilingly and with courage.

The important stabilizing factor in Beth's development was not *whom* she turned to for support but that there was some *one* person able to gain her confidence in her terrible loneliness and insecurity.

Inner Strength

In many instances the stabilizing factor is the patient himself. We have all seen the patient who seems to have all the odds against him, but because of some stamina, some strength of character, will be able to win through. Sometimes this is so obvious that everyone who knows the patient is sure of this. But in other instances it may be hidden from view so that even though we believe we know the patient well we are unaware of his underlying strength.

The patient-students at the Hospital School included for many years a boy, whom we shall call Bill, who was a paraplegic and had all the complications of that condition. He did not do well in school. He tried all of the vocational courses and failed or was disinterested. Moreover, he never followed instructions in caring for his own personal needs, although he had been taught patiently over a period of years.

Bill's mother and father were divorced and his father's whereabouts was unknown. His mother visited him occasionally but as she lived in a rooming house she was never able to take him for vacations.

Bill talked to the social worker over and over again, pleading for a chance to live on "the outside," a term used by the patients for any community outside the institution. This raised a number of questions: What would he do? Where would he live? How would he care for himself? Would people tolerate his lack of personal hygiene? The social worker suggested that he might use his last year at the Hospital School to prove he was able to care for himself. But he did not change. Bill's desire and difficulties were taken up with his mother, in the hope that she might offer to get an apartment for him, but she became hysterical, crying that if the personnel of the Hospital School wanted to take the responsibility of letting Bill out it was up to them, but she knew unqualifiedly he belonged in an institution.

On the other hand a psychiatrist, consulted by the social worker about Bill, reported: "I can certainly understand the misgivings about him in view of his past performance and I realize that this 'just give a chance' cry is often the prelude to failure. However, I believe that the odds are good enough to warrant the trial. If he is the sort who cannot play his best unless the chips are down, he will make the grade. On the other hand, if he is a psychopath he will never make it no matter what is done. Unfortunately, with the circumstances under which he has lived so far, there is no clear-cut way to make an absolute prognostic differentiation. My advice would be to make the trial if at all possible. There is more to gain than to lose."

So with things not looking very promising plans were made. No one really expected them to work, but the staff agreed that Bill should be given a chance. A room was found, temporary help from the public welfare agency was arranged, and the State Division of Vocational Rehabilitation agreed to make plans with him.

Everything went completely to pieces within 5 weeks. Bill was put out of his room because of his lack of personal hygiene; he refused to go to the sheltered workshop on the grounds that the Division of Rehabilitation was giving him the "runaround," and he turned to the Hospital School for help. This was denied him as he had been given his chance, and he was advised to accept permanent institutional care.

Then, when he was completely up against it, Bill found himself a job and found a boardinghouse in which to live. He is still with both 3 years later. He has been responsible for four other physically handicapped boys getting placed in the same factory, has bought a car and has turned into a steady, reliable young man. As the psychiatrist sensed, he turned out to be the kind who "plays best when the chips are down."

Community Spirit

The fact that a hospital school is a community of people with similar problems and interests can be a supporting factor in rehabilitation. If a handicapped child can manage at home and in a public school where he has more normal living, a hospital school has nothing to offer. However, if the severity of his handicap, his family's or his own poor adjustment to it, or a combination of factors necessitates his admission to a hospital school, the spirit of the community can be of tremendous value. There the sympathy he will get will not be maudlin; in fact, quite the opposite. He will have to stand with the other children on the strength of his personality—on what he is. But he will not have to face the reaction of others to his physical difference for he is expected to have one. Such casual acceptance of his disability may help him to accept it himself. As he learns to do more for himself within his own limitations, and as he becomes more mature, he can then begin to take the next step toward fitting into a world of nonhandicapped people.

An integral part of this community is the help the students can and do give each other. Their freedom of expression is not hampered by self-consciousness about their handicaps. They discuss their mutual problems and work them out in their own ways. They joke about their differences, saying amazing things to and of each other. They can also cut through barriers that a person who is older or without a handicap cannot do. One girl told a friend: "Go on, feel sorry for yourself, it will get you nowhere but you can wallow in it if you want."

Sometimes such forthright treatment by a contemporary does more for a child than any older person could do. The children also see their friends going into the mysterious "outside" and doing well. All this bolsters their courage.

Something of this spirit at the school must have had a hand in building up Bill's determination to make good on the outside. In spite of all the uncertainties of the staff *he* had never had any doubts.

Another example of the value of the institution's community atmosphere can be found in the case of a girl who was referred to the Hospital School with a fairly mild type of disability. Although she could get around well she walked with a mild spastic type of gait which was awkward and noticeable. She had been in public school and had done well until she reached high school when her marks dropped drastically for she had become aware of her difference and was desperately unhappy. At the Hospital School, however, everybody had a "difference". Her adjustment there was rapid and her school marks immediately improved. She continued on at the Hospital School until she was graduated from its high school. By that time she had regained her confidence enough to enter college. In her first year of college she has not made a spectacular record but has done well and, more important, she has been able again to feel comfortable in a group of predominantly nonhandicapped people.

Time can be another stabilizing factor. Certainly the medical profession depends upon and recognizes its value in allowing nature to heal. Time, or more correctly, what can take place as time passes, may also heal social ills. Frequently families who have paid little attention to their children in their early days at the Hospital School have eventually renewed their interest and have even become supportive and helpful. This has not always come about spontaneously, but often as a result of the social worker's understanding attitude toward parents, her gentle but constant prodding, and her reports on their child.

Time as a Healer

When a child is born with a handicap the shock to the parents is severe, arousing feelings of helplessness and hopelessness, and sometimes feelings of guilt. But after time goes by and the child develops personality and learns to do more for himself, the hopelessness lessens. If the parents can be persuaded to take the child home they sometimes find, to their surprise, that he is accepted by their neighbors with much less difficulty than they expected. As they find others responding with affection to their child and themselves become proud of what he can do, they may gradually take up the reins again.

There is a little boy at the Hospital School who was born without any arms and with one leg shorter than the other. His father's devotion has never varied, but his mother was so hurt psychologically by this shock that she could deal with it only by avoiding him. Her reaction to him made it necessary to place him in another institution until he was old enough for transfer to the Hospital School.

During his year at the Hospital School, this mother has gradually become less disturbed. While the boy's first visit home was difficult and he cried to come back with "the kids," his periods at home have gradually increased, the last one being 2 weeks long. The other children in the neighborhood play with him; he is part of their gang. This boy has learned to do amazing things with his toes, and his mother just recently said with pride—"he can do almost everything."

No pressure has been put on her. The social worker agreed with her when she suggested that if the boy stayed home too long he would have difficulty readjusting back at the Hospital School, although it was evident it was really too hard for her to keep him any longer. Nevertheless progress is being made as her hurt is lessening.

Sometimes when hope seems very dim, an unexpected factor enters in to bring stability—call it chance, coincidence, or fate.

Until a few years ago Eleanor, a girl severely handicapped with diffuse arthrogryposis, a congenital condition of joint deformities and muscular weakness was a student at the Hospital School. She had been born out of wedlock and placed in a foster-family home where, because of the severity of her handicap, care could not be maintained. She was therefore admitted to the Hospital School at the age of 2 years, although today the school would be more adamant about such a young child's need for the individual love and care of a family home. At the age of 15, Eleanor was found to be incapable of further education and unable to profit from vocational training because of poorly functioning hands. Wheelchair bound, she was worrying about the future and fearing transfer to another institution.

Little else seemed to be in store for Eleanor because her mother had rejected her almost completely, writing only rarely from her home in another State. However, her mother did ask Eleanor in a letter where she would go when she had to leave the Hospital School; and Eleanor in answering named another State institution to which she would probably be transferred. Her mother immediately came up to the Hospital School, greatly concerned. She told the social worker she had been deserted by her own mother when she was 7 years of age, and because of her need for medical treatment had been sent to the institution Eleanor had named, and had lived there for several years. Eleanor's mention of the institution brought back vividly the unhappiness and loneliness of this experience, and with these memories came the realization to this mother, perhaps for the first time, of what she had done to her own daughter.

After some months of planning, Eleanor finally went to her mother's home in the faraway State. The adjustments were bound to be many, between Eleanor and her mother and stepfather, for they did not know each other. But at least there was a chance for this young girl to live outside an institution for a while and to hope for a brighter future.

A Philosophy

The Hospital School has not always been as fortunate in finding solutions to children's problems as in the cases presented here. There have been failures—the family who did not come to accept their child in spite of time, patience, and understanding; the student who failed to respond to any kind of appeal or therapy, preferring to remain dependent; many others representing struggle, suffering, and defeat for child and hospital personnel alike. Nevertheless, the Hospital School's philosophy persists—never to give up, while a child is under care, the effort to seek out and build on the stabilizing factors which can sustain his future.

A MATERNAL AND CHILD-HEALTH SERVICE ON THE EUPHRATES

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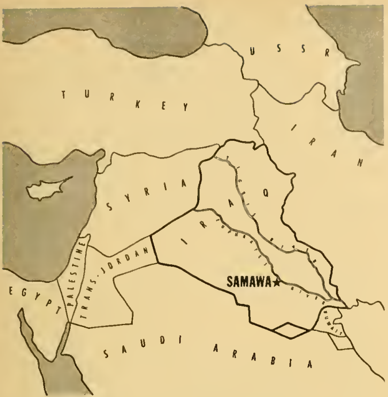
IN FEBRUARY of 1953, three American women—a pediatrician and two nurse-midwives—climbed aboard the "fast" train from Baghdad for Samawa—and so began, under joint auspices of the Iraqi Ministry of Health and what was then the Division of Public Health of the U. S. Operations Mission the first rural maternal and child-health unit for this Arab country. This climaxed a busy 2½ months of preparation for the three Americans, beginning with intensive orientation in Washington in the Children's Bureau, the U. S. Technical Cooperation Administration offices and the Foreign Service Institute and followed by lessons in Arabic and meetings with Iraqi students and professional people in the United States. En route to the Near East, introductions to technical-assistance health projects in Lebanon and tours of clinics and hospitals of Baghdad had served further to bring home to us some of the vast differences in language, customs, health habits, diets, and diseases which we would have to meet and learn to understand. When the friendly ticket collector and our fellow passengers on the Iraqi Railroad asked in amazement, "What are you going to do in Samawa?" we had to muster all our optimism and self-confidence to tell them about the plans for developing services to mothers and children.

We were welcomed at the Samawa station by the local physician and by the U. S. Technical Assistance consultant in maternal and child health who, with officials of the Iraqi Ministry of Health, had planned the Samawa project. They had traveled extensively over the country, interviewing the chief medical officers of the 14 districts and inspecting the towns and their hospital facilities, and had chosen Samawa as a representative town for a demonstration project. A town of about 20,000 inhabitants located on the Euphrates, Samawa is a trading center for farmers whose lands are watered by the Euphrates irrigation systems and for Bedouins of the desert who raise

The maternal and child-health programs described in the accompanying article grew out of a plan recommended to the Iraqi Ministry of Health in 1952 by Dr. Walter C. Price, U. S. Technical Assistance consultant on maternal and child health attached to the Iraqui Ministry of Health. Dr. Price was sent to Iraq by the U. S. Government in 1951 in response to a request for an expert in maternal and child health to help develop the new Ministry's program.

The establishment of the Ministry and its proposed emphasis on "preventive and social medicine" was in line with a recommendation from a mission previously sent to the country by the International Bank for Reconstruction and Development. Iraq, wealthy with new-found oil resources, had requested a review of the country's economic potentialities and the formulation of a long-term program for their development.



sheep, goats, and camels and, having no fixed homes, follow pasturage for their animals.

As we rode through the streets that first day we were overwhelmed with the numbers of children we saw everywhere and wondered how we could ever serve such a multitude. We also passed a continuous heavy traffic of loaded camels and donkeys, men pushing carts laden with dates and date-palm mats, barefoot women completely enveloped in their black cloaks, carrying bowls of leban (sour milk) on their heads, little boys with large river fish, Bedouins driving lambs ahead of them, neatly dressed students with armloads of books, and Government officials in European dress going to their offices. Eventually we came upon a small hospital building which had been erected by the local child-welfare society. Because doctors and nurses are scarce in Iraq, especially in rural areas, the hospital had been vacant for 2 years and was now available for our use.

Immediately we pitched in to scrub and clean the hospital. It was quite unlike an American clinic building and since it had stood unused for so long, it was in a very rundown condition. Rains had soaked the roof, leaving great peeling patches of plaster; floors were of soft cement which had crumbled; water pipes had no connection to any source of water and drains were completely blocked by debris. Since we were at the tail end of the town electric lines, only enough current to make a few wires glow came through the bulbs, so that after dark we had to use lanterns and flashlights.

Our cleaning equipment consisted of palm-leaf brushes which we had to use without the help of soap, cloths, or scouring powder. We did, however, have willing Iraqi helpers, and with our few Arabic words, plus a good many gestures and demonstrations, we were able to set up the rudiments of a maternal and child-health clinic.

News travels fast in and around Samawa. The first evening after our arrival a group of Bedouins came in from the desert carrying a blanket by its four corners, containing an exhausted woman who had been in labor for days and seemed unable to deliver her baby. The American and Iraqi nurse-midwives went into action. Since most Iraqi women will not allow male doctors to touch or even see them the technical-assistance consultant and the local physician lined up solemnly with the tribesmen on benches outside the doors. The patient's mother prostrated herself on the floor, faced east, and began to pray, while a most hesitant pediatrician applied forceps. Thus was born our first Iraqi baby and officially or unofficially, we were open for business.

From then on requests for medical care were overwhelming. Mothers began at daybreak to line up outside the hospital gates with their children. Because we were unable to handle such numbers we soon had to limit our child-health services to infants under one year of age. Expectant mothers began to come in for delivery—at first only those who were having difficulties and then gradually others who were experiencing normal pregnancies, for examination, preventive measures, and dietary advice.

Staff and Equipment

Our staff, both Iraqi and American, gradually increased. The first addition was an Iraqi codirector and obstetrician, the first woman graduate of the Royal Medical College. A great deal of credit for whatever success the project achieved belongs to this competent woman, with her enthusiasm and interest, her knowledge and understanding of her people and their problems, and her patience and willingness in helping the Americans to adjust to a culture very different from their own.

Soon after we opened our clinic a male medical technologist from the U. S. Public Health Service arrived to set up our laboratory. Finding housing for a man proved even more difficult than for women and for several months he inhabited the hospital storeroom with a makeshift bed and a package of iodoform gauze for a pillow.

The technical-assistance consultant stayed with us

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a short time as liaison officer and was active in procuring supplies, contacting the Iraqi Government, and struggling with our many problems of personnel and equipment. He slept in one of the examining rooms and when women and children began to arrive for clinic he had to fold his bed "like the Arabs and as silently steal away."

A graduate pharmacist was assigned to us as Iraqi technician but after one year was called to the army.

Next to join our staff was an American pediatric nurse who taught both clinic and hospital nursing to the Iraqi staff. She also held informal classes for mothers every morning with simple demonstrations in feeding, bathing babies, and general good health habits. Arab mothers, like mothers everywhere else in the world, are interested and eager to see and hear about what is good for their babies.

A young Iraqi physician heard about our project and came down to study pediatrics with us. He was a help not only in treating babies but in helping with our public relations, for being a Moslem doctor he knew the people and their customs well.

At first we operated only clinic and emergency delivery services, but on assignment of four Iraqi nurses we opened the hospital ward and began training a group of six young Iraqi girls in midwifery. This course was supervised by the two American nurse-midwives who gave intensive instruction in prenatal, postnatal, and delivery care. Since the students were girls with very little education and only one year of nursing, the course of necessity included a good deal of general nursing techniques, clinic procedures, and even lessons in English.

The first class of health visitors trained in Iraq from the Technical Assistance-Basra Health Unit received their maternal and child-health instruction at our center. This group of 10 eager girls took a concentrated course including prenatal and postnatal care, some practical pediatric and obstetric lessons, well-child and newborn care, and techniques and supervised experience in home visiting.

Within a year the physical setup had changed a great deal from its primitive beginnings. By that time it included: a large hospital ward for maternity patients and newborns, and an outpatient department, busy 6 days a week, with three rooms for prenatal clinics and deliveries and three rooms for pediatrics and demonstration projects. The hospital has its own electric-power plant, sterilizing equipment, and electric air-cooling system. Faucets now flow with clean running water from a new city water plant, instead of muddy river water directly from the Euphrates. A small and efficient laboratory is housed in a separate building. Garages, a new kitchen, storerooms, and laundry have been added. Four prefabricated housing units are in use by staff members and a temporary "prefab" dormitory of 15 rooms provides living quarters for the Iraqi girls who are learning midwifery and child-health nursing. At this writing the Iraqi Government is putting up a group of permanent buildings for personnel, which will soon be finished.

Mothers and Babies

In our first year and a half, we saw 3,300 babies in 16,600 clinic visits, and 2,000 expectant mothers in 8,000 clinic visits. We believe this included most of the babies and new mothers of Samawa plus many from the surrounding countryside. Since births and deaths are not usually officially recorded in Iraq our clinic records were about the only available sources for estimating the infant population of the community.

Attempting to collect any type of information in Samawa was a frustrating experience to a western mind. The language difficulty was only one of many hurdles. The rural Arab woman has only a vague sense of time, and the age of her child seems of little importance to her. Even his name is not fixed in infancy and he may be called Ahmed one day, Riath the next, and something else later on. This plays havoc with a record system. Name cards given to mothers on their first clinic visit are little help as they are passed around to various friends of the family and used as admission tickets to the clinic. We had to be constantly on the alert to spot substitutions of either mother or child—or both.

Child-care customs in Samawa are basically different than in Western countries. From time of birth the baby is tightly wrapped, with legs extended, arms folded and head covered, even in hottest weather. The material used is almost always a silk or rayon crepe, even among the poorest families, as it is considered a shameful thing to use cotton clothing. The navel cord is tied with a piece of wool cloth and the stump padded with loose raw wool (a harbor of tetanus germs), ashes, and sometimes donkey manure. The baby's eyes are heavily painted with a black substance called kohl, the body with henna powder, and the folds of axillae and the groins touched with a bright red dyestuff called zeracun—said to contain mercury though we never saw any signs of mercury poisoning in babies. If the baby is feverish or weak, or if the weather is cold, a generous supply of donkey manure is added to the whole lower part of the body.

A baby usually arrived for his first visit at the clinic with a rusty knife wrapped with him to cut away evil spirits. His head, apparently considered dangerous to wash, was usually encrusted with layers of dirt, sometimes enhanced by a coating of leban alternating with a layer of henna so that the hair could hardly be seen. This crust often had become infected underneath so that the baby had to be practically scalped to get to healthy skin and promote healing. In Iraq, baby feeding is almost exclusively by breast. Some mothers are afraid to give their babies water even in the heat of summer, which reaches 125° F.

The desert home and family of the first woman delivered in the maternal and child-health center in Samawa. The women have gathered to welcome the nurse on her postpartum visit.

As the baby emerges from the 6-week newborn period, he is put in a short dress of bright-colored rayon, silk, or velvet. This is never changed, winter or summer, though a jacket may be added if the family can afford it. While a few of our clinic babies wore little pants of a single layer of fancy material. only 3 babies out of our 3,300 wore anything resembling a western-type diaper. Socks are rarely worn. Even in freezing weather infants sit on the concrete walks barefooted and barebottomed, but never bareheaded. Heads may be wrapped in colored scarfs or adorned with caps, gay with embroidery and always a blue bead or charm to frighten away the "evil eye."

Young infants are carried either under the mother's all-enveloping black cloak or, by the Bedouin women, in hammocks of rough woolen cloth, slung over the back by a headband. Older infants ride astride one shoulder of mother or sister.

The babies are, on the whole, quite late in walking and their leg muscles are very flabby, with marked ligamentous relaxation and knock-knees, due partly to being tied down so much and partly to poor nutrition. They receive solid foods only after a year or even later. The average baby in Samawa from 6 months to 1 year in age is behind in weight, in general nutrition, in dentition, and especially in muscular tone.

The problem of infant feeding is one of major importance in Samawa. Since the mothers are usually very anemic and on substandard diets, after a few months their breast milk is inadequate for the calorie needs of the growing baby. Sweetened water and tea, weak solutions of powdered milk, milk mixtures from goats, cows, sheep, camels, and water buffalo, heavily diluted with water, are then used. The mechanics of feeding are also difficult for it is almost impossible for the mothers to get bottles and nipples properly cleaned. The development of immunity to intestinal infection must begin very early in life if these babies are to survive.

At the Clinic

Custom, climate, poverty, and superstition combined to put formidable barriers in the way of promoting good preventive health care. One of our greatest allies, however, was the mothers' eagerness to promote their babies' health. While it was difficult to explain to them the reasons for hygienic methods of child care, when we showed them how to wash their babies and take other health measures they often were impressed enough to adopt whatever they could of these methods in their home care.

We immunized a large number of the 3,300 infants against diphtheria, whooping cough, tetanus, typhoid fever, and smallpox. Whooping cough, which in former years was very prevalent and undoubtedly accounted for a good many infant deaths, was comparatively rare in 1954. We saw not a single case in infants from the town, though we did see a few cases in children brought from nearby communities. We also saw no cases of infant diphtheria after the immunization program began. We also saw no cases of typhoid fever, which seemed somewhat of a miracle in view of the low standards of sanitation generally prevailing.

The diseases we treated most frequently were diarrhea, conjunctivitis, otitis media, impetigo and allied skin infections, and, during the winter season, pneumonias of various types. Tetanus among the newborn, seen for the first time by the American members of the staff, was a frequent problem.

Prematurity was also a frequent problem in Samawa. About 70 of the 700 newborns seen at the clinic were premature babies, and nearly half of those weighing under 5½ pounds at birth died soon thereafter. The center is currently studying the causes and results of prematurity in the area.

On the whole there was marked improvement in the home care of the clinic babies. This was especially noticeable in first babies and in babies of mothers who had attended the prenatal clinics. Mothers also learned to bring their infants to the clinic early in illness instead of waiting until the babies were very sick. Some of the mothers became regular visitors to the clinic for the whole of the baby's first year of life!

Some Infants

The death rate of infants and young children in Samawa is very high in comparison with western countries. In 1,800 families studied, 9,000 babies have been born and over 3,000 of these have died, a death rate for this group of 350 per 1,000 live births. Chief causes of death are pneumonias, septicemias (including tetanus of the newborn), diarrheas, and prematurity. The maternal and child-health center at Samawa is making a frontal attack on that rate. What this has meant to mothers and babies can best be told in the stories of a few of them.

Faisal's mother brought him to the Samawa Clinic when he was only 5 days old. Weighing just 4½ pounds, he was so little that his mother, who had never had any babies, was afraid to hold him. Both baby and mother were very apprehensive and often were crying together. Our nurses encouraged the mother to feel more confidence in her ability to handle her little Faisal, answered her many questions and showed her how to feed, bathe, and dress him. The clinic doctor examined him frequently, keeping records of his growth and development and treating him when he was ill. Faisal visited the clinic 38 times during that first year and in addition to receiving careful examinations went through the clinic's gamut of immunizations. Now past his first birthday he is a plump little boy, and his mother, ready to have another baby, is attending the prenatal clinic.

Seven-day-old Fayak was brought to the clinic by a hopeless father, who realized the child was suffering from the dread tetanus disease. Fayak's temperature was 106° F. His little jaws were clamped tightly shut and he was convulsing almost constantly. He was given a large injection of antitoxin and a

Modern sanitary conveniences are few and far between in Samawa. These steps down to the Euphrates are used by women to get to the river's edge to do their washing and by boys and men who wish to take a cooling bath in hot weather.

large dose of penicillin. The pediatric nurse, who had been especially trained in caring for newborns, put a tube into the baby's stomach through his nose so that he could be given the food and medicine which were necessary to his survival. The treatments were continued twice daily for 10 days until the little boy finally opened his mouth to take food the natural way.

Of the 15 babies seen at the clinic with this severe and usually fatal disease, 4 have been saved. The other 11 did not return after one treatment. The clinic cannot hope to cure all cases of tetanus in the community, but it is teaching people how to prevent it. Fayak's family and friends are now telling their neighbors to tie the umbilical cord with a clean cotton string and thereby keep out the germs living in the customary raw wool dressing.

At least 15 babies seen at the clinic, and probably many more, died of pneumonia. Since this is not only a curable but often a preventable disease the clinic is teaching the Samawa mothers to bring their babies to see a doctor when they get colds or coughs instead of trying grandmothers' remedies, getting various medicines from the *suq* (shopping area) and even resorting to *chonie*, or multiple burning of various areas of the baby's body. One baby, whose mother had previously lost 5 babies, had made a total of 55 visits to the clinic by the end of his first year of life and the staff bade him *feimanileah* (farewell), knowing that his mother had learned how to take better care of him and to take him to a doctor when he became ill.

In the long hot summer months in Samawa everything dries up and suffers from lack of water, even the babies! Some of them, especially the very young, quickly become very ill with dehydration and diarrhea. Thirty of our 3,300 clinic babies were listed as dead, or probably dead, from this cause.

One of the clinic's objectives is to teach mothers proper feeding for infants in hot weather—how to keep the baby's food clean and his fluids adequate so that he will not become dehydrated or succumb to that number-one killer of infants, diarrhea and dysentery. Occasionally we had a gratifying surprise as in the case of Ali Mohammed, who was brought to the clinic dry as a chip and looking like a shriveled little old man. Since he was vomiting and could not retain milk or water, he was given fluid under the skin. Medicines were prescribed and the mother shown how to get Ali to take them.

Ali and his mother were part of a tent-dwelling Bedouin tribe which was moving on the next day; so we shook our heads in sorrow and put Ali's record into the files as "probable death" for we did not see how the baby could possibly survive the desert sun plus his diarrhea and dehydration. However, 6 months later when the tribe changed grazing lands again, Ali came to see us, a big healthy boy of 15 pounds.

Maternity Patients

The first patients in the maternal clinic were for the most part postpartum patients with complications or women with sterility problems, but gradually women learned to come into the clinic early in pregnancy for regular teaching and supervision. Many of the women coming for normal spontaneous deliveries were young wives having their first babies, while others were patients who had had trouble previously.

We found that most of the expectant mothers were anemic and badly needed iron and liver therapy as well as dietary advice.

Most of the early deliveries were of women who came to us in a very bad condition. Exhaustion, toxemias, hemorrhage, and infection were our chief problems. The clinic tries to teach prevention of these complications to patients and to the nurses.

Zabna, an older woman, had been married for 12 years without producing any children—an especially tragic situation for an Arab wife, as she must produce a son to have proper standing in her household. When Zabna at last became pregnant, she was very happy. She came to the prenatal clinic and tried to do everything the doctor and nurses advised. She wanted to come to the hospital to have her baby but when the time came well-meaning relatives told her frightening tales and tried to persuade her that old ways were best. She stayed at home for 2 days with constant company urging her on with every pain. When nearly exhausted she insisted on coming to the hospital. By that time she was so tired that she did not have much strength, and forceps had to be used to deliver her 10-pound baby boy.

Transfusion is a new and frightening thing to desert Arabs who find it difficult to believe that nature will replenish the blood taken away and that no harm will come from donating small amounts. Kitba was an unhappy little woman who was full of hookworm and so weak and anemic that she could not stand alone. Her greatest need was for some blood cells. We sent for her husband Ahmed, a tall strong Bedouin, and told him why she was so tired and pale. Ready at once to do anything to help his wife, he begged us to take all the blood we might need. We took enough to give Kitba two small transfusions which put her on the road to recovery. Now Ahmed is helping to spread the word that giving a little blood is easy to do and that transfusion helps anemic women who are having babies.

Thus through its direct work with individuals, the maternal and child-health center in Samawa is not only helping mothers and babies in emergencies, but is spreading the word about good health practices to the surrounding community. As individual women of Samawa, both rich and poor have become convinced of the skill of the center's staff from firsthand experience in time of labor difficulty or their baby's illness, they have tended to heed the staff's advice on preventive measures and to spread the word to neighbors and friends.

Many difficulties have been met in establishing and operating the project and some of them have necessitated a change in emphasis. While the project had been initially conceived as a school for training midwives for rural areas throughout the country, this goal had to be modified when it became apparent that the isolation of Samawa—actually a desert oasis—made it impossible to get Iraqi staff in sufficient numbers to carry out the instruction and supervision such a plan would entail.

What will happen when American personnel leave the center cannot be definitely predicted, but indications are that a system of sending rotating medical and nursing staff to the area will be initiated by the Iraqi Government. This will enable the center not only to serve directly the mothers and babies of Samawa, but also to demonstrate to Iraq's health personnel the methods of setting up and operating a maternal and child-health service that can be used in establishing similar centers in other parts of the country—centers which are now sorely needed in both urban and rural areas.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

A FAIR CHANCE. 30 minutes, sound, black and white, purchase.

Illustrates work done under the State-Federal Crippled Children's Program. Through teamwork between public health and education departments, a schoolboy's rheumatic fever is detected and he receives hospital and convalescent care. He is thus enabled to return home to normal life.

Audience: General public, in this country or abroad.

Produced by: Caravel Films for U. S. Department of State.

Distributed by: United World Films, Government Film Department, 1445 Park Avenue, New York 29, N. Y.

FIRE IN THEIR LEARNING. 45 minutes, sound, color or black and white, purchase.

Shows how children's interest in a local happening (in this case a fire) was skillfully directed by their teacher so that it extended into many related fields of school work. Through the discussions the children acquired knowledge that might some day save their lives.

Audience: Parent groups; teachers colleges.

Produced by: Presentation, Inc., for the National Commission on Safety Education of the National Education Association.

Distributed by: National Commission on Safety Education, National Education Association, 1201 16th Street NW., Washington 6, D. C.

ROLE PLAYING IN GUIDANCE. 14 minutes, sound, black and white, purchase or rent.

By means of role-playing in which a boy takes his mother's, his own, and his school principal's parts, in turn, a teacher helps a 13-year-old work out a solution to a problem he would have found it very hard to discuss openly with his teacher. The purpose of the film is to demonstrate how role-playing may be used to bring out different points of view and underlying feelings.

Audience: Any lay adult group interested in learning methods and techniques of group discussion of the problems involved in human relations; for high school and college students under skilled leadership.

Produced by: Motion Picture Division, Department of Theatre Arts, University of California at Los Angeles.

Distributed by: Educational Films sales Department, University Extension, University of California, Los Angeles 34, Calif.

FORGET NOT THESE CHILDREN. 22 minutes, sound, color, purchase or loan.

Depicts part of New Jersey's program for mentally deficient children. The film emphasizes the help given the more capable children, especially the older girls, and shows how they are taught skills that will help many to earn a living.

Audience: The general public.

Produced by: Princeton Film Center for the New Jersey Department of Institutions and Agencies.

Distributed by: (sale) Princeton Film Center, Princeton N. J.; (loan) Mrs. Pauline Thyfault, Bureau of Community Service, 222 West State Street, Trenton, N. J.

How the combined effort of a number of agencies is leading to . . .

BETTER NUTRITION FOR PUERTO RICANS

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QUERER ES PODER—*Where There's a Will, There's a Way*, the title of a Puerto Rican nutrition film, is a motto that has proved its validity over the past 12 years to persons and groups concerned with improving nutrition on the island. The film was one of the early activities in a coordinated effort begun in 1943 among agencies on the island to deal with a problem which is both serious and widespread in the area.

In Puerto Rico poor nutrition is one of the reasons behind an infant mortality rate of 67 per 1,000 live births (1951) and a maternal mortality rate of 22 per 10,000 live births (1950–1951). Arising from serious deficiencies in the consumption of protective foods, it is also a factor in much of the morbidity on the island, including a high tuberculosis rate and a high rate of anemia among mothers and children. That it lurks, too, among those who are not included in the mortality and morbidity statistics can be assumed from the prevalence of conditions which are often symptomatic of poor nutrition—small stature, poor teeth, cheilosis or cracks around the mouth, toad skin, bleeding gums, poor visual adaptation to darkness, and low physical resistance. Height-and-weight studies have shown that Puerto Rican children are about 2 years behind children on the mainland in physical development.

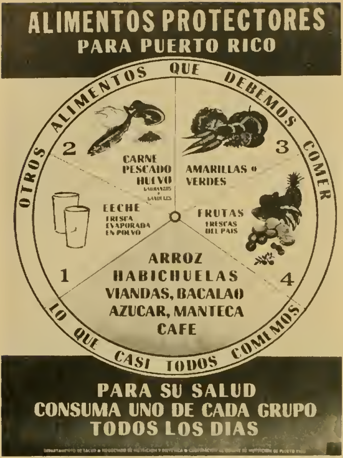
The nutrition deficiencies in Puerto Rico are unquestionably greatly determined by such facts as the island's overpopulation, limited land, and low economic condition. In 1940 the income in Puerto Rico was $122 per capita. In 1949 this figure had risen to $319. A decade of inflation played its part in this rise but some of it can also be laid to increased agricultural and industrial activity. As the government continues its efforts to provide better and more steady incomes through agricultural and industrial programs, more families will have more money to spend on food and other life essentials.

However, better income alone is not enough to insure good nutrition. More money spent for worthless foods will not improve diets; but some improvement can be achieved, even with low incomes, with wise spending on low-cost nutritious foods.

Actually in Puerto Rico as in other countries malnutrition is not limited to the poor, nor to people in rural areas, nor to illiterates. It is prevalent in the country and the city, among the rich and the poor, and among professional and lay persons.

Recent research has shown that the consumption of food per year per person in Puerto Rico is much lower than that recommended for good nutrition.[1] Even more significant are the findings on the kinds of food eaten. The greatest volume of consumption is in such foods as flour, starchy vegetables, and rice—while consumption of protective foods such as milk and fresh vegetables is low. Observation in hospitals, clinics, schools, and everyday life also indicates that a great number of Puerto Ricans live on a deficient diet—not at a starvation level but having a diet partly inadequate in many of the essential constituents, especially high-quality protein, vitamin A, and calcium.

Puerto Rican food habits have changed over the past decades as processed products or "foreign" plants and seed have been introduced from continental United States. Not all the change has been to the good. The people tend to prefer foods of lower



The Basic Four poster used in nutrition education in Puerto Rico stresses the value of milk; meat, fish and eggs; green and yellow vegetables; fresh fruits of the country.

nutritive value, some of them imported at relatively high cost, to foods of greater nutritional merits native to their own land. For example: they are apt to like the less nutritious white sweet potato better than the vitamin-rich yellow sweet potato, or protein-low kidney beans better than protein-rich pigeon peas and chick peas, which contain higher-quality protein. But one relatively inexpensive food imported from the mainland they tend to shun. Although their island does not produce enough milk to meet minimum needs, many Puerto Ricans refuse to use evaporated or dried milk, mistakenly believing it to be of unequal food value to the fresh product or even to be harmful.

A century ago the Puerto Rican family planted and consumed greens such as chard or the tender leaves of yautia, a root vegetable. But a few years ago he who dared to plant greens and bring them to market would run the risk of having them go to waste because the people would refuse to buy what their grandfathers had appreciated.

Fads and fallacies affect Puerto Rican diets. Many families have guava, breadfruit, or mamey trees growing in their yards but they let the fruit go to waste because they have heard that guava "may cause appendicitis," that mamey will "poison them," or that they will "become blind" if they eat breadfruit.

Poor nutrition in Puerto Rico is not, therefore, a consequence only of low income. It also arises from a lack of information. It was a realization of this that, 15 years ago, prompted the various service and educational agencies in the island to form a Nutrition Committee with the purpose of combining their efforts to provide the needed information and to take other steps to improve diets and dietary habits on the island. This was the beginning of an integrated program, which has grown in strength and determination over the years as agencies have become accustomed to working together and as the serious shortage of nutrition personnel has, through their own efforts, been somewhat alleviated.

Among others, the following organizations are actively participating: vocational-education and school-lunch programs of the Commonwealth Department of Education; the University of Puerto Rico; the Agricultural Extension Service of the U. S. Department of Agriculture; and the Commonwealth Department of Health through its Bureau of Nutrition and Dietetics and through the local public health units serving the Commonwealth's 77 municipal jurisdictions, which cover both urban and rural areas.

Feeding Programs

While the main emphasis in this coordinated nutrition program is educational, extensive feeding programs are also under way to improve the chances of children for healthy growth. These programs concentrate on children and on expectant and nursing mothers. They reach 237,657 school children, 23,710 preschool children, and 12,000 infants and lactating or pregnant women. The programs for school and preschool children are operated by the Commonwealth Department of Education with combined funds from the Federal Government and the Commonwealth of Puerto Rico. They provide the school children daily with well-balanced lunches and the preschool children with midmorning meals.

The program for mothers and infants has an educational as well as a feeding purpose. Operated by the Commonwealth Department of Health through 200 milk centers located throughout the island, it provides pregnant women and mothers and babies participating in the clinics of the 77 local health units their entire daily requirement of milk as determined by the clinics' doctors. These milk stations have been established not only to distribute milk but to acquaint mothers with good health and nutrition practices. Legislative appropriation has provided the necessary funds.

Recipients of these services are required to have a real need for them. That they do is evidenced by the long distances many mothers walk every day to receive the milk. Some mothers carry home milk for as many as three small children—a newly born, a 1-year-old, and a child just under 2 years of age.

The nutrition program also stresses better feeding of sick persons. Some hospitals and institutions have well-trained dietetic staffs continuously trying to provide the best possible food with the funds available. In addition, surplus food donations from the U. S. Department of Agriculture's Office of Food Distribution have increased considerably the food value of the hospital diets during the past year. Surplus foods have also been provided to certified tuberculosis patients attending clinics in the Public Health Units.

This program is now being extended to noninstitutionalized individuals under medical referral. Among those who will receive surplus foods are needy crippled children, cancer patients, and pregnant women who are living too far from the Health Units to be able to attend milk stations daily.

This use of surplus foods is not only providing sick people with diets more inducive to recovery or better health, but is also affecting favorably their attendance at clinics, their regularity in coming to the Health Units for treatment, and their acceptance of the treatment offered.

Educational Activities

When the coordinated nutrition program got underway in Puerto Rico the available nutritional information was mainly in English and about those foods used habitually on the mainland, giving little information about native foods. Nutritionists and educators at first had a tendency to underrate Puerto Rican foods, which they saw chiefly as rice and beans and starchy vegetables, and to glorify menus typically found in the United States. Puerto Ricans looked on nutrition education with an eye of mistrust, fearing that it would disparage the foods they had liked for generations in favor of a long glass of milk and a salad plate.

Under the coordinated nutrition program scientific research undertaken at the School of Medicine and other parts of the University of Puerto Rico soon provided information about a variety of native foods which could be used as a basis for evaluation. All the agencies engaged in the program now show respect for Puerto Rican food habits and attempt to stimulate good practices in regard to foods once used but forgotten. They emphasize possible substitutions within Puerto Rican dietary patterns in an effort to get acceptance of more nutritious diets. People are now urged to consume better legumes, the best starchy vegetables, and as much milk, native fruits, and fresh vegetables as possible.

To bring this about the agencies are using a variety of teaching and educational methods. Exhibits, posters, demonstrations, and dramatizations have all been used to present nutrition information. Efforts are made to reach professional and lay persons, adults, children, and the aged with the facts about the good nutritive qualities of many Puerto Rican foods such as the famous West Indian cherry or *acerola*.

Home Food Production

Many children in Puerto Rico are being taught how to grow some of their own food through cultivation of school gardens. The program stresses both the educational and supplementary feeding values of such gardens and discourages individual schools from regarding them merely as showpieces or entries in prize competitions. Schools are encouraged to give the food produced to the children either in the school-lunch program or for use in home-economics classes.

To encourage home economists and nutritionists to stimulate this program the University of Puerto Rico is offering a course in home food production to all students in its Home Economics Department. A well-qualified agronomist, a member of the Puerto Rico Nutrition Committee, is in charge of this course which at present includes rabbit and goat raising besides vegetable gardening.

Publications and Visual Aids

Because Puerto Ricans are a Spanish-speaking people and have certain food habits markedly different from those of other Americans, the Puerto Rican nutrition program has had to develop its own educational materials in Spanish adapted to resources, educational level, economic conditions, and food habits on the island.

There is still a great need for pamphlets and leaflets in simple language, as well as for movies, film strips, and slides. Since the funds and facilities available to produce such teaching materials are very limited, nutrition workers of the various agencies have agreed to work together to make the best possible use of what is prepared. Thus, the health department's Bureau of Nutrition and Dietetics makes its educational material on milk and fruits available to all the other agencies engaged in nutritional activities. The Agricultural Extension Service also provides copies of its leaflets on consumer education to all agencies, including the Commonwealth Department of Health.

When two members of the Puerto Rico Nutrition Committee prepared a film strip called "Puerto Rico Golden Treasure" on the Puerto Rican pumpkin, *calabaza*, the various agencies purchased a total of over 150 copies. These are in constant use all over the island.

Because the Basic Seven chart, commonly used by nutritionists in the United States, is not adaptable to Puerto Rican food habits nor to the economic condition of Puerto Rican families, the nutritionists on the island worked together for 2 years in discussion and experimentation to determine what basic foods should be emphasized in a nutrition program for Puerto Rico and how they should be recommended. They finally arrived at what is now known as the Basic Four: four groups of food which are presented as necessary supplements to the rice, beans, and starchy vegetables of the customary Puerto Rican diet. Chosen to correct the nutritional deficiencies of this diet by introducing foods rich in calcium, protein, and vitamins A and C, they are:

1. Milk—fresh, evaporated or dried—for calcium and vitamin A.

2. Meat, fish, eggs, pigeon peas, or chick peas, for proteins.

3. Yellow and green vegetables, for their mineral content and for vitamin A.

4. Native fruits, for vitamin C.

After agreeing on these four groups of protectors, the nutritionists worked out the details of a poster which could be used as the major tool in their educational efforts. This involved coming to agreement on such details as the order of importance in which the foods would be presented, the decision not to recommend any specific amounts of food for consumption, and the wording of the poster. As finally prepared the chart forms a circle representing a well-rounded diet. One section presents those foods, largely starches, commonly consumed by Puerto Ricans as valuable dietary ingredients but deficient as a complete diet. The circle is rounded out with four more sections representing the Basic Four foods.

The facts that this poster has been prepared as a cooperative undertaking of all the agencies concerned with nutrition in Puerto Rico and was designed by Puerto Rican workers to meet the needs and customs of Puerto Rican families have assured its acceptance and use. The first printing of 3,000 copies proved to be insufficient to meet the demands of teachers, agricultural workers, nurses, and others engaged in nutritional education, and second and third printings have had to be made. Funds have been supplied by the Bureau of Nutrition of the Commonwealth Department of Health.

Other printed materials prepared under the coordinated nutrition program include a leaflet on goat raising as a source of milk supply, another on the uses of dry skim milk, and a third emphasizing the Basic Four foods, called "Better Food for Your Family." These materials, however, are insufficient to fill all needs. Additional materials requiring very little reading ability are especially needed for adults who have had no more than a second- or third-grade education.

Laws and Regulations

The long-term objectives of the nutrition program include legislation to complement the educational activities. A number of important laws have already been achieved, two of them instigated by the Puerto Rico Nutrition Committee. One requires the enrichment of all wheat flour and wheat-flour products sold in the Commonwealth, and the other requires the enrichment of rice. These laws assure all Puerto Ricans a more nutritive diet than they formerly had. Since Puerto Ricans consume an average of 143 pounds of rice per person per year the rice law is especially important.

New and revised regulations within the Commonwealth Department of Health have also come about as a result of the nutrition program. A number of these have been made to encourage the use of dried skim milk.

Puerto Ricans do not consume enough milk for an adequate diet, largely because many of them cannot afford it. The milk supplied by the government through the milk stations and school-lunch programs is insufficient to reach everybody needing it. However, if families having a little money to spend for milk would invest it in dry skim milk they would be able to get more milk for their money. This has not been the custom for a number of reasons. In the first place the people have known very little about dry skim milk or its nutritive value. What experience any of them have had with it is apt to have been with a product used to feed calves or with a low-quality variety once donated to them, which was inferior in taste, appearance, and ease in preparation. Moreover, until the regulations were changed, the Commonwealth Department of Health required all dry skim milk to be colored in order to prevent its use in fresh-milk adulteration.

These are the conditions which prompted the Commonwealth Department of Health to repeal its regulation on color and to establish a new regulation calling for small containers, Spanish labeling, and certain information on the labels to assure proper use of the product and to prevent adulteration.

Once the importation of dry skim milk came within the new regulations the Nutrition Committee prepared a simple leaflet offering demonstrations anywhere on the island to show people the value of this product and methods of preparing it and to give them a taste of it, especially in coffee. Finally a film was made called "Más Leche Para Todos," or "More Milk for Everyone."

Dry skim milk now is being distributed in the school-lunch program, to hospitals and institutions, and to outpatients in clinics. It is also available in stores in most urban and some rural areas. However, many people are still reluctant to purchase the product. Moreover, in small stores in rural areas, where it is most badly needed, it is less likely to be found for these are the places where distribution is most difficult and costly.

A class of mothers in one of Puerto Rico's many milk stations watches a nurse from the public health unit demonstrate ways of preparing native fruits for feeding the baby.

Personnel Training

In Puerto Rico, as elsewhere, the quality of work can never rise above the level of training. With this recognition the program has from the beginning considered special ways of providing up-to-date training in nutrition and nutrition education. One of its greatest achievements during the past years has been the steady progress in developing more and better-trained nutrition workers. A number of developments have contributed toward this.

Realizing the importance of the nutrition problem and the need for a more intensive nutrition-education program, the Secretary of Health of Puerto Rico in 1951 created a Bureau of Nutrition and Dietetics in the central office to serve the entire Health Department as well as other agencies. The Department had given a considerable amount of nutrition services previously through a nutrition section attached to the Bureau of Maternal and Infant Hygiene in the Division of Public Health. The staff of six nutritionists has been tripled and two new dietary consultants appointed.

The Bureau provides consultation services to physicians, nurses, teachers, and other public-service personnel and conducts training meetings and workshops for them. In all its training activities it emphasizes the importance of strengthening the nutrition program in line with the needs of the people as determined by diet studies, food customs, and available facilities and resources.

Until recently students who had graduated from the University of Puerto Rico and wanted to undertake graduate work in nutrition had to go to the mainland for such training. Now, however, the university offers a graduate course with the cooperation of the Children's Bureau of the U. S. Department of Health, Education, and Welfare, and the Commonwealth Department of Health. Since the course is still on a demonstration basis without permanent university status, it does not yet lead to a master's degree in public-health nutrition—a goal for the future.

The University of Puerto Rico is also the setting of the first and only approved internship of the American Dietetic Association outside of continental United States. The Municipal Hospital of San Juan and the Veterans Administration Hospital are used as the training centers.

Does It Work?

Not everything envisaged by the nutrition committee has succeeded. Many difficulties have been encountered and projects started which did not progress as planned. One of these involved the mass planting of fruit trees along the roadsides. The project was started, but drought, lack of personnel, and lack of material impeded it.

Such setbacks, however, have not killed the enthusiasm of the Committee or of the nutrition workers cooperating in the program. They continue to set their sites on two main goals:

1. To stimulate research that might uncover treasures of hidden natural food on the island or warn of unmerited selections and to spread the findings wisely and rapidly.

2. To keep the program realistic and practical by suggesting food habits which are within the means of the people.

While it may be desirable for all children to drink a quart of milk a day, who has the heart to tell a mother of 10 children, with hardly any money, that she must buy 10 quarts of milk a day? For the time being, she can only be told: "Milk is important; buy as much as you can."

This focus on the nutritional resources and needs in Puerto Rico does not prevent the program from producing results that may be valuable elsewhere. In spite of the shortage of good material for nutritional education on the island, Puerto Rico offers what it has to other countries that can make use of it. Many requests have been received from South American and Central American countries in need of Spanish-language materials. Students from these countries have also come to Puerto Rico for training and to learn ways of adapting the Basic Four poster to their own countries. Puerto Rico has also supplied English-speaking areas in the Caribbean with information on the food value of tropical foods.

Is the program proving effective? Are people being better fed? The answer is definitely "yes." Although data cannot be supplied to show how many people have learned to eat foods new to them, there is a great deal of evidence that they have.

Ten years ago no yellow sweetpotatoes could be found anywhere for sale on the island. The only place nutritionists could find one was in the garden or the horticulturist of the Agricultural Extension Service. Today the yellow sweetpotato is planted on a commercial scale and is sold in every market and by many street vendors. It is used in all hospitals and institutions.

A visit to the market place offers much evidence of the program's success. There you now find certain fruits such as guava and certain vegetables which before were not considered worthy of a place on the stand. *Somebody* is buying these fruits and that somebody must have learned that they are among the most nutritious foods in Puerto Rico. Again, in many stores large and small, in towns and rural areas, either powdered or evaporated milk is now being sold. *Somebody* has learned that it is as good as fresh milk and is consuming it.

More evidence of the program's effectiveness has come from the head of the U. S. Department of Agriculture's food-distribution program in Puerto Rico, who recently stated: "After 3 years of hard struggle I can say that the children getting school lunches have learned to like and accept milk."

Much has been attained, much more is still to be done, but we in the nutrition program feel we are going in the right direction by working together and giving each other suggestions for bettering nutrition on the island. We have achieved enough together to know that a forceful and effective educational campaign on nutrition can be undertaken through a joint program of workers in various fields. We know too that the end results of such a program cannot be attained in a month, a year, or even in a century. Many steps must be taken and many difficulties must be overcome, but each advance will mean a better-nourished and hence a stronger and healthier population in Puerto Rico.

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[1] Roberts, L. J.; Steffani, R. L.: Patterns of Living of Puerto Rican Families. Chicago: Photo Press, Inc., 1949. (pp. 182–390.)

A TEAM APPROACH IN PREVENTING MALADJUSTMENT

MARION ROBINSON

Writer, Community Research Associates, New York

LATE IN 1954 in a California community, the curtain rang up on a demonstration research project which will, for the next 3 years, intimately involve the children of that community's troubled families. The potential gains which may accrue from the experiment—in furthering community-wide planning for the prevention and reduction of major human problems, in new documentation of the crucial importance to such planning of child welfare and family services, in moving toward more stable family life for these and other children—may be enormous but are as yet unpredictable.

Aimed toward "prevention and control of disordered behavior," this local demonstration project is part of a $2 million "package" of research experiments directed by Community Research Associates of New York City, a nonprofit organization for social research and community surveys. The total 5-year research plan is underwritten by three foundations—the Grant Foundation, New York City; the Hill Family Foundation, St. Paul, Minn.; the Rosenberg Foundation, San Francisco, Calif.—with supplementing funds from local and State sources.

The general purpose of the projects is to test, demonstrate, and develop a thesis, presented 3 years ago in a comprehensive treatise by CRA researchers.[1] Documented by findings from a community-wide survey made in St. Paul, Minn., in 1948, this volume suggested that the gigantic health and welfare enterprise which has grown up in the past century in this country should be so organized as to prevent and reduce the major ills of our communities' people.

CRA found in the course of the St. Paul study that the three most serious problems, in terms of prevalence among the communities' families and drain on available professional skills as well as health and welfare dollars, were economic dependency, ill health, and maladjustment. It is important to note that in defining "maladjustment" they followed the modern psychiatric teaching that the roots of antisocial behavior, mental and emotional illness, and family disorganization lie in the same dynamic soil. Thus in measuring the size and shape of the community's maladjustment problem they included those problems and services found in the fields of corrections, mental health, and social casework.

Each of three current community projects is concentrated on one of the major problems. The common objective is to see if the incidence of the problem can be affected by attacking it at its point of greatest concentration, through the integrated services of a psychiatrist-psychologist-caseworker team in collaboration with other specialists and local resources. In each instance, effort is primarily directed toward helping the community carry out its corporate responsibility for dealing with these human problems. The general project plan offers a service to the communities' individual agencies, but a more important service is its provision of a way in which available agencies can make an integrated, concerted attack on a total problem.

Perhaps the most dramatic finding of the St. Paul study was the one which put a pinpoint on the concentration spot of these community problems. Although 23 percent of St. Paul's families were being served by one or more of the 90-odd public and private agencies and institutions, a group comprising about 6 percent of the community's families suffered from such a compounding of problems that they were absorbing more than 50 percent of the services of all agencies in the dependency, health, and adjustment fields. This amounted to what is known in public-health language as an epidemiological fact—a fact about a community-wide problem which holds a clue to constructive action toward its prevention and control.

The small group of families which were found to represent the hard core of human misery in the community are referred to by CRA as "multiproblem families." They have furnished a good deal of thought for prevention-minded planners. It was found that they accounted for 77 percent of the relief load, 51 percent of the drain on health services, and 56 percent of the load carried by the adjustment services in the corrections, mental-health, and social-casework fields.

Follow-Up Studies

Comparable studies[2] conducted in the past 3 years in the three widely different communities chosen for the current projects have validated and illuminated the St. Paul findings. In Winona, Minn., the services of 46 local and State agencies were reaching about 12 percent of the families in the county. The multiproblem group amounted to 5.8 percent of the county's families. In Washington County (Hagerstown,) Md., 49 agencies were serving 13 percent of the families, and the multiproblem group represented 5.9 percent of the families in the county. In San Mateo, Calif., where 74 agencies were working with 11 percent of the families, again the multiproblem group comprised 5.8 percent of the families in the area.

Finally, the three more recent studies showed that the "multiproblem families" accounted for from 70 to 88 percent of the relief load, from 63 to 90 percent of the health-service load, and from 43 to 56 percent of the load carried by the adjustment services.

It seems clear that any effort to make an appreciable dent in these serious community problems must deal with the "multiproblem families." Indeed, it can be said that in these demonstration projects, as well as in a project now being conducted under the auspices of the Planning and Research Council of Greater St. Paul as a followup of the original study, help for the multiproblem group constitutes the first line of attack in the push to make prevention a reality.

The problem of dependency is the focus of the Winona project. Here the preliminary study showed, as had the St. Paul study, a high incidence of chronic illness and handicap among dependent families. This clue to the cause of dependency has had considerable influence in shaping the project. In 1953, when the initial study was made, 53 out of every 1,000 families in the population were chronically dependent. About a third of these were families with children under 18. Three-fifths were couples or single-person families. In half of all families, the head of the household was 65 years of age or over.

The Winona project is aimed toward rehabilitation of "multiproblem families" where dependency is a complicating factor, rehabilitation of the disabled, and rehabilitation of the able aged. Parts of the preventive program now in various stages of operation call for a mass X-ray and medical-examination screening of all families in the aid-to-dependent-children program, extension of the community's public-health nursing and homemaking programs, and experimentation with a physical-therapy program. A medical social worker is a valuable member of this project team.

In Washington County, Md., where the project is directed toward the problem of ill health, the study showed that, in terms of what put the greatest burden on the community's financial and professional resources, "indigent disability"—disabling conditions which require community assistance—was the crux of the health problem. Among 2,000 families receiving community or tax-supported health services, a group of 1,115 contained 1,273 persons who were disabled. These families accounted for 69 percent of the county's relief load and 56 percent of those receiving community-provided medical care. About half of all the expenditures for welfare, health, and social services in the county was being used for their care. This project, which began operation in the fall of 1954, involves both rehabilitation of those already disabled and a detection program to reach and treat people with potentially disabling conditions.

Study of Maladjustment

San Mateo County is a suburban area stretching out from the San Francisco city line. Its rapidly increasing population now stands at 300,000. Its people are young and prosperous. The median age in the population is 31.4 and only 6.3 percent of the population is 65 or over. The median family income is $4,467, which is considerably above the median for the United States.

In 1953, $16 million were spent in the county for community and tax-supported health, welfare, and recreation services, a per capita expenditure of $51. About $10 million of this comes from tax funds which break down about equally between local sources and

State-Federal sources. A little less than $600 thousand comes from voluntary contributions. About a third of the total budget represents amounts paid by the consumer for services received. A little more than $4,375,000 was being spent for aid to the dependent, more than $3 million for services to the maladjusted, and somewhat less than $2½ million for health services.

During January 1954, when CRA made the initial study of the county's services, 9,851 families were receiving some service from one or more of the 74 agencies and institutions. Of this group, 5,456 were being served or cared for because of some evidence of maladjustment of one or more members of the family. Nearly half of these were "multiproblem families."

Further search for "points of concentration" of maladjustment in the community showed that, in terms of what was putting the greatest burden on community resources of money and professional skill, the problem which these researchers labeled "disordered behavior" constituted another line of attack in the job of prevention. It was found that, of these 5,456 families, there were 2,816 where there were various evidences of such "disordered behavior." This is at the rate of 30 out of every 1,000 families. About $2½ million of San Mateo's $3 million budget for adjustment services was being spent for families so defined.

The term "disordered behavior" is used in this study to cover six specific classifications of socially abnormal behavior or situations evidenced in individuals or families, in respect to which communities usually take some action. The term is entirely dissociated from implications of moral judgment or causation; it simply refers to the obvious presence of socially abnormal factors of direct concern to the community.

The six classifications include: unsocial juvenile behavior (delinquency, truancy); separation of children from their own homes through placement by agency according to a definite plan (in foster homes, institutions, homes of relatives and friends); crimes indicative of family disorganization (nonsupport, neglect, abuse); structural evidence of family disorganization (divorce, separation); major crimes; inmates of mental institutions. Because of limitations in resources, the last two categories are not being included in the current San Mateo project.

After concentrated study of this group of 2,800 families, the "prevention spotlight" finally came to rest on a group of 1,267 families where there were children under 18. These families accounted for all juvenile misbehavior brought to the attention of agencies, all children separated from their own homes through community agencies, almost *all* the reported divorces and separations, and about half the crimes indicative of family disorganization. As the project began to function, these families constituted a top-priority group for screening and diagnosis.

Key to Planning

A basic concept of this research group is that the key to preventive planning lies in a family-focused diagnosis and treatment plan made by a team integrating the skills of psychiatry, psychology and casework. Thus, in the structural setup of the San Mateo project all roads lead into and out of the Family Research Center. The Center's director has had extensive experience in both family and child welfare, and came to the project from California's State Department of Mental Hygiene where he supervised psychiatric social services. The diagnostic team currently includes three caseworkers, a psychologist, and a psychiatrist. A medical internist and a group worker serve as consultants to the team in this phase of the project.

The former San Francisco area director for the California State Department of Social Welfare serves as general director of the project. CRA's associate director for adjustment services is project supervisor.

By an agreed-upon procedure with both public and private service agencies all new cases falling into any of the six classifications are reported automatically to the Family Center, with special flagging to indicate families with children under the age of 18. A cumulative roster which began with the families reported in the initial study is an important tool in the task of keeping the precise size and shape of the community's total maladjustment problem constantly before the team. Referral for diagnosis, again a procedure agreed upon between the team and the agencies in the course of setting up the project, comes from the agency to the team. It is specified in the agreement that the agency will use the diagnostic and consultative service of the team in cases specific to this research—families with children under the age of 18 and a situation falling into one or more of the six classifications.

The team approaches each case in terms of the total family situation. Materials necessary to the diagnosis are furnished or secured by the agency or agencies involved, and agency workers become part of the diagnostic team operation. Family Center personnel do not deal directly with families, do not accept direct applications, and do no treatment. In making this comprehensive family diagnosis, case by case, schedules and materials developed in CRA's family diagnostic and classification project are being used. This is a research undertaking in collaboration with about 70 caseworkers and supervisors in the family agencies of seven cities. Briefly, the purpose of this research is to forge the tools for better diagnosis and classification of seriously disorganized families.

The final diagnostic picture shows not only the troubled person or persons against the background of the family of which he is a part but also the total family situation as a functioning unit with the troubled person in it. Particularly careful work is done in evolving a treatment plan which will make effectively integrated use of specialized services needed by individual family members.

Integrated Treatment

The treatment plan includes agreement as to which agency will carry the primary responsibility for the case, with the agreement resting on factors revealed by the total family diagnosis. The pattern of treatment arrangements varies in each of the three communities where these demonstration projects are in operation. One might say they are "custom-made" to suit the varying resources of the Center and the communities. In San Mateo the Center team members do no treatment. In Winona and in Washington County different arrangements allow for team members to work either as part of agency staff groups or to collaborate with agency practitioners in carrying out treatment plans. In all three communities, however, community resources, particularly of trained caseworkers, are being utilized to the highest degree, with agency agreements providing for the time and skill of certain professional workers to be diverted into the project process.

In San Mateo community agencies which can best provide the kinds of treatment indicated by the diagnosis work together to carry out the treatment, with continuing consultation of the interdisciplinary team available to the personnel involved. Where a family is not already known to an agency whose services are indicated as needed, following preliminary diagnostic work, the agency which requested the team diagnosis follows its usual referral procedure in drawing the needed agency into formulation of the treatment plan.

Procedures for "case management" by the Family Research Center during treatment are being evolved. "Case management" is a term borrowed from the health field, and refers to a kind of social-welfare adaptation of community experience in prevention and control programs directed toward community-wide health problems. It covers a cluster of detailed agreements which in these early months of the demonstration are constantly being tested and evaluated. The sum and substance of the agreements and their evolving amendments is to determine the most effective balance of responsibility between the Center team and the agencies involved, with the prime objectives of keeping systematic track of progress or the lack of it and testing this against the original diagnosis, as well as appraising results at periodic intervals in preparation for a final evaluation at the termination of the project.

The purpose of this aspect of the project is to test the thesis of this research group that an integrated approach by community agencies to troubled families, particularly those families suffering from a clustering of problems calling for different specialized services, is called for in the task of reducing the size of a serious community problem. The leadership of the Center team means that integrated interdisciplinary work is at the center of a process which brings agency services to bear appropriately in relation to the family diagnosis and in the perspective of the total family situation. It will be possible after more experience in the project to evaluate the relative values of this kind of integrated diagnosis and treatment and the familiar piecemeal treatment of various family members by various community agencies, each having partial knowledge, or perhaps no knowledge, of the others' treatment plan.

The crucial relationship to this research plan of social casework in general and of family and child-welfare services in particular is obvious. The ability to evaluate and treat family factors, even in cases of mental and emotional disturbance which must be dealt with by psychotherapy, is of basic necessity to the successful operation of the entire process. Moreover, situations such as are presented by the multiproblem families have for some time been dealt with in a preventive and rehabilitative manner by professional caseworkers in voluntary agencies, and in more recent years by child-welfare divisions of public welfare departments. Thus, a body of knowledge and experience significant to the experiment has been built up.

In all three project sites, CRA researchers and local leaders have had to work hard to overcome the undeniable problem posed by the insufficiency of casework services. In Winona two of the caseworkers on the staff of the Family Center work as part of the local department of public welfare staff in order to meet the needs of both the Center and the welfare department during the lifetime of the project.

In San Mateo, CRA's initial study showed a serious gap in available caseworker services. Although California is strongly aware of the values of mental hygiene and psychiatry, social casework, particularly family-oriented casework, can scarcely be said to have taken hold.

San Mateo County today boasts of about a dozen and a half qualified casework practitioners in local family and children's services, both public and private. The principal service agencies are well aware of the shortage and are making realistic efforts to increase the supply. In the meantime a premium has been put on ways and means for making the most constructive use of the skilled service that is available in carrying out this particular project. The need for a more adequate supply of qualified caseworkers in many of our American communities has been presented so often that it has become a cliché. This California community is demonstrating to itself in each step of the project, beginning with the report on the initial study, the irreplaceable value of these services in dealing with its community-wide problems.

The remarkable cooperation of community leaders in planning and setting up these projects, which present a considerable challenge to a community and its resources, has greatly encouraged these researchers. Representatives of local and State agencies serve as valuable members of project advisory boards, and adapt the service patterns of their agencies so as to gear in with the basic plans of the projects themselves. In differing ways and degrees, local and State personnel and funds are helping to meet total project budgets.

One might well expect that the vested interests and pride of autonomy which exist in the health and welfare world, just as they do in other parts of American life, would present insurmountable problems in working out the project plan. On the contrary, the enthusiasm with which San Mateo's leaders regard the goal of prevention and reduction of the maladjustment problem and the reasonably sensible plan offered for achieving it, has reduced such problems to a position of minor importance. It may well be that lack of definitive ideas about "how to cooperate about what" will prove to have been the biggest single obstacle to service integration.

A Fresh Approach

There is, after all, nothing new under the sun. Families with many problems constitute no new phenomenon to our practitioners. Probably no caseworker ever lived who did not look with despair at the generation-to-generation sequence of serious human problems which is the heritage of too many of our children and wonder "how can I really help this child who has two strikes against him right from the beginning?" Neither is there anything new in the idea of trying to prevent human misery and rehabilitate those who suffer from it. The same knowledge and skills which our service agencies are daily bringing to bear on these problems, each with a satisfying score of successes, are being used in these experiments.

What this research group has done is to take a fresh look at old problems, take precise measurements on a community-wide basis, deploy available resources according to an integrated plan, and make a bold effort to attack these problems at the heart. If the preventative plan is sound, it will enable agencies to do a better job, to increase their opportunities for success, and to show the community more clearly the true significance of the services they render.

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[1] Bradley Buell and Associates: Community Planning for Human Services, New York. Columbia University Press, 1952.

[2] The Prevention of Dependency in Winona County, Minn., July 1953. The Prevention and Control of Indigent Disability in Washington County, Md., July 1954. The Prevention and Control of Disordered Behavior in San Mateo, County, Calif. July 1954. Community Research Associates, 124 East 40th Street, New York, N. Y.

PROJECTS AND PROGRESS

World Congresses Affecting Children

Last fall two important conferences affecting children took place across the Atlantic, one at Zagreb in Yugoslavia, the other in The Hague, Netherlands.

The World Child Welfare Congress which met in Zagreb had a threefold purpose—to protect children from conditions contrary to their welfare; to provide them not only with food, shelter, clothing, education, and recreational opportunities, but with the special individual services they may require and to prevent those occurrences that affect children adversely.

Some 450 delegates and auditors from 28 countries attended the Congress. Throughout their discussions they exhibited an intense interest in the maintenance of the family as a unit. They also emphasized the importance of providing help to children at the time it is needed, of respecting rights of children in the selection of their vocations, and of avoiding the use of tags such as "illegitimate," or "delinquent," in considering their needs.

The Congress was divided into four sections, the first dealing with the healthy child in the normal family. Among other findings, this section recommended that countries center their social policy upon the family, that the child within the family be the first to benefit from improved social conditions, that a system of supplementary allowances make it possible for mothers to work no more than half time outside the home, that education for parenthood begin during the years of compulsory education and perhaps be extended for boys during their military service. This section also called on the International Union of Child Welfare to set up a committee "to study, plan, and stimulate ways of raising the standard of parental care throughout the world."

Section II considered the child separated from his family for reasons of health or education. Emphasizing the harmful effects of separation of young children from their mothers this group recommended the avoidance of hospitalization unless absolutely necessary through the extension of facilities for home treatment and the planning of children's hospitals to allow mothers to be admitted along with their children. Among other recommendations the section asked for greater opportunities for the personality development of physically handicapped children and for the employment of handicapped young people over 15; the provision of suitable services in the home or community for the treatment, education, and vocational training of mentally deficient children; the participation of the family in the treatment of the socially maladjusted child.

Section III focused on the child in the problem or broken family—including children born out of wedlock, children of divorced parents, and neglected, ill-treated, and exploited children. The section agreed that children born out of wedlock need special protection to ensure them equal opportunity with other children for personality development; that marriage counseling services should be available to families contemplating separation; that casework methods should be used to improve the family environment of ill-treated children; and that their parents' rights be withdrawn only as a last resort.

Section IV considered family relationships in exceptional circumstances, such as war or natural calamity. This section agreed that children should be separated from their families only when such a move is necessary to ensure their physical survival. Here again as throughout the Congress, the delegates expressed their strong conviction of the importance of preserving the family as a unit, "no matter what are its customary standards."

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The Sixth World Congress of the International Society for the Welfare of Cripples, which met at The Hague, brought together more than 700 persons from 36 countries to discuss programs for the care and rehabilitation of crippled children and adults throughout the world.

The central theme, "Changing Attitudes in a Changing World," revealed the widely held conviction that no substantial and far-reaching progress can be hoped for without adequate understanding on the part of many citizens as to the purposes, methods, and content of rehabilitation programs. The theme was set forth on the opening day in a keynote address by Dr. Henry H. Kessler of the United States, who took note of the important advances in many countries in the provision of rehabilitation services and cited the need for a change in attitudes towards the disabled as fundamental to progress.

At a meeting on parent education, Dr. C. Schaap of the Netherlands urged that more attention be given to the attitudes of parents toward their handicapped children and to efforts to determine when the needs of the child can best be met by placement in an institution. A number of speakers reported on development of parent groups in several countries and their participation in the establishment and development of programs for handicapped children.

Delegates interested in special education heard participants from England, the United States, and Austria discuss the merits of residential schools for handicapped children and special educational programs that enable such children to live in their own homes and attend school.

Addresses in the Medical Section concentrated on the importance of participation by all medical and related specialties in services to crippled children.

Three papers in the Social Section, presented by speakers from the Netherlands, France, and the United States, emphasized the need for broadly conceived social-service programs in order to bring the family and community into full partnership in the rehabilitation team.

A series of meetings planned by the ISWC Committee on Prostheses, Braces, and Technical Aids attracted a large number of delegates. Reports on recent developments in research, manufacture, and fitting of prosthetic appliances were heard, and attention given to the problems of making sufficient trained personnel available to provide adequate service in this area. The results of an international survey of personnel needs in the field of prosthetics were also discussed.

In the closing address, Dr. William T. Sanger of the United States noted that while mankind has come a long way in the development of attitudes towards those who deviate from the normal, much remains to be done before these attitudes are based on accurate information and humane judgment. He advocated greater support for organizations which are demonstrating that, with appropriate services, the disabled can play an important part in the world's progress.

Leonard W. Mayo,
Director, Association for the Aid of Crippled Children, New York

Health Officers

Early last December health officers from the 52 States and Territories gathered in Washington for the annual meeting of the Association of State and Territorial Health Officers and for their annual conference with the Surgeon General of the U. S. Public Health Service and the Chief of the Children's Bureau. The latter conference was also attended by the State mental-health authorities and representatives of the State hospital survey and construction agencies. Both meetings resulted in numerous recommendations for furthering health services, many of them concerning services to children.

The Association of State and Territorial Health Officers spent considerable time discussing the methods whereby Public Health Service grants are made to the States. They eventually proposed a block grant with sums identified for specific categories and carrying permission for the States to transfer certain percentages of funds from one category to another. Funds for crippled children's and maternal and child-health services would remain as separate allotments granted through the Children's Bureau.

Two of the Association's recommendations concern prophylaxis against poliomyelitis. One asked that the State health department be relieved of its distribution of gamma globulin for poliomyelitis prophylaxis, and the other that the States undertake the administration of the Salk vaccine when and if it is licensed and released.

Blindness in babies received particular attention in two recommendations, one asking the State maternal and child-health directors for continuous study, evaluation, and report on the prophylaxis of ophthalmia neonatorum, an eye infection in the newborn, and the other urging use of the latest known methods for the prevention of retrolental fibroplasia. This recommendation also urged measures to prevent kernicterus, or jaundice in the newborn.

Along with a number of recommendations in regard to mental health, the health officers urged the integration of mental-health principles with all nursing practices and the intensification of mental-health programs and facilities in public-school systems.

Steps to improve services to migratory farm families were also recommended. These included: Federal grants to States along the migratory routes to strengthen local services and to provide for pilot studies; study by a committee of the Association of ways of financing medical care for this group; continuous study and implementation of the recommendations of the East Coast Conference on Migrants.

The Association urged by resolution that voluntary groups call conferences within each State to assess the progress of official health services and to promote citizen interest and support.

Most of the recommendations that came out of the conference with the Surgeon General and the Chief of the Children's Bureau were of an administrative nature, designed to facilitate current operations and to provide for better coordination among the agencies concerned. Among other goals these sought: the drafting of model State legislation applicable to local health units; greater coordination of leadership for school health services; the development of definitions and research tools for measuring the various types and degrees of mental disorder and mental deficiency in the population; finding ways for health and agricultural agencies to promote the health of farm families; facilitating continuity of health services to migrant laborers and their families; and the establishment of standards for housing and sanitation in migrant camps.

Against Polio

If evaluation of the Salk vaccine shows that it offers effective protection against paralytic poliomyelitis, the National Foundation for Infantile Paralysis will supply the vaccine without charge this spring for all 7,750,000 school children in the first and second grades of public, parochial, and private schools in the United States, Alaska, and Hawaii, as well as for the 1,390,000 children who served as controls in the 1954 trials.

A plan for the administration of the vaccine has been worked out jointly by representatives of the Foundation, the American Medical Association, the American Academy of Pediatrics, the American Association of State and Territorial Health Officers, the American Public Health Association, and the U. S. Department of Health, Education, and Welfare. This provides that the administration of the vaccine in any State will be the responsibility of the State health officer, who will work out a plan for the inoculations in cooperation with the State medical society and State education officials. Additional vaccine is expected to be available to private physicians through commercial channels. After 1955, the National Foundation will not participate in the production, distribution, or administration of the vaccine.

No extensive nationwide evaluation of the 1955 program is contemplated, but individual States may decide to conduct followup studies on their own initiative.

Juvenile Delinquency

Pennsylvania's State Department of Social Welfare, with Federal financial help from the Children's Bureau, has had a survey made of the State's 24 public and private training schools and other institutions for juvenile delinquents. The survey, made by the University of Pennsylvania's Institute of Local and State Governments, was recommended by the Governor's Committee on Children and Youth and the training schools themselves.

In its report the Institute notes that the institutions' basic problem is that they are not welded into a coordinated system and that their relationships with the juvenile courts, State agencies, and the counties "show no semblance of a closely knit, planned, and well-coordinated statewide program of institutional care."

The Institute is now making a supplementary study of these relationships as a step toward suggesting an overall coordinate plan for services to delinquents on a statewide basis.

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The Citizens Committee on Children of New York City recently presented a report to the Mayor's office, based on a 7-year investigation of New York City's program to combat juvenile delinquency. The report calls for improvements in the public-school system's Bureau of Attendance and its schools for emotionally disturbed children and strengthening of the Police Department's Juvenile Aid Bureau and the Children's and Magistrates' Courts. It also urges expansion of detention facilities, additional State facilities for juvenile delinquents, and training programs for professional personnel employed in all parts of the delinquency program.

Mental Health

Social isolation among adolescents is not necessarily followed by development of schizophrenia, according to the results of a 2-year research project of the National Institute of Mental Health, Department of Health, Education, and Welfare.

The sociologists who made the study compared a number of hospitalized schizophrenics with the same number of persons in the community at large, matching individuals by age, sex, and occupations. Each person supplied information on his residential and occupational history, family relationships, adolescent friendships and activities, dating, adult social life, and physical illnesses.

Considerable social isolation during adolescence was found among the schizophrenic patients, but the isolation itself did not appear to be the predisposing factor, according to the investigators, nor did it seem to intensify the severity of the schizophrenia.

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Increased emphasis on the mental-health aspects of growth and development will be given by the Elizabeth McCormick Fund, according to a report recently issued by the organization. Under its current plans the Fund will focus mainly on encouraging research but it will also offer consultation and carry out special projects in its efforts "to enhance the opportunities for every child to achieve the full measure of his potentialities."

The report of the Fund's activities over the past 45 years clearly illustrates the changing emphases in services to children during the period. Starting in 1908 with measures for saving infant lives in Chicago, the Fund shifted its emphasis in the early 1920's to the broader fields of health education and health supervision.

Orphans

In mid-1953 about 2.9 million children under 18 years of age in the United States, or 1 in 20 of all the Nation's children, had lost one or both parents by death, according to an analysis made in the office of the Commissioner of Social Security, Department of Health, Education, and Welfare. In 1920, when the child population was only three-quarters as large, there were more than twice as many fully or half orphaned children: 6.4 million, or 1 in every 6 of the children under age 18.

Children who have lost both parents amounted to 750,000 (2 percent) in 1920; the number declined to 450,000 (1 percent) in 1930, and to 66,000 (⅛ of 1 percent) in 1953.

The Commissioner's office points out that this decline, combined with increasing emphasis on foster-home care and the public income-maintenance programs, has lessened the need for institutions for the care of orphans. At present almost half of all children in this country whose fathers have died are receiving benefits under the old-age and survivors insurance program, and about 1 in 7 receives compensation or a pension as a survivor of a veteran. In all more than three-fifths receive benefits under one or both of these programs or another form of social insurance. More than 1 in 10 of the children whose fathers have died receives aid to dependent children; many of these are ineligible for social insurance; others receive social-insurance benefits, but not in an amount large enough to meet their needs.

Hearing Loss

A 5-year study of the effectiveness of irradiating excess lymphoid tissue in the noses and throats of school children has recently been completed in Baltimore. Undertaken as a check on one part of a hearing-conservation program in the schools, the study focused on the 582 third-grade children who were found through examinations to have actual or potential hearing loss—more than a tenth of all the third graders who had been screened at the time the study was begun. All of these children received "treatment" but for a random half of them this included the use of radium and for the other half the use of inert materials.

All the children still available were examined twice a year during the 5 years of the study—385 in all at the end of the period. The last hearing tests on these showed, on the average, as much improvement among the children who did not receive the radium as among those who did. However, among the children whose initial hearing loss was greatest, the 43 who had received radium had improved much more than the 29 controls. Other evidences of better status of the treated group were found in the condition of adenoids and the nasopharynx.

The study was a joint project of the School of Medicine and the School of Public Health, both of Johns Hopkins University, and was carried on with the cooperation of the education and health departments of the city of Baltimore under grants-in-aid from the Public Health Service, United States Department of Health, Education, and Welfare.

Nursing Education

The close community of interest between the social-work and nursing professions stimulated the American Association of Medical Social Workers to make a study of nursing education which has recently been reported in a pamphlet, "Medical Social Work Looks at Nursing Education," by Eckka Gordon, director of social service at the Grace-New Haven Community Hospital, New Haven, Conn.

Citing as evidence the more than doubling of collegiate nursing schools in the last 20 years, the report notes an increasing trend toward better preparation of nurses. It points to the following improvements within these schools: a trend toward patient-centered teaching programs; richer curricula encompassing training in mental hygiene and the development of a core of knowledge common to all the nursing specialties; more socially oriented teaching. However, it also notes that only about 11 percent of today's nursing students are in courses leading to an academic degree.

Prepared under a grant from the National Foundation for Infantile Paralysis, the report is available for $1 from the American Association of Medical Social Workers, 1834 K Street NW., Washington 6, D. C.

The Cerebral-Palsied

A report of a study of more than a thousand cerebral-palsied boys and girls has been made public by the International Council for Exceptional Children. The children were examined between 1936 and 1951 in clinics conducted by the New Jersey State Crippled Children's Commission. All were between 1 and 21 years of age.

Birth injury was the reported cause of the palsy in the largest percentage of the children—39 percent. In 28 percent the cause was described as "developmental." Each of the other causes listed, such as prematurity and the Rh factor, accounted for the palsy in less than 10 percent of the children.

The report questions the correctness of the belief that a child with cerebral palsy is usually a firstborn. Analysis of half the cases in the study showed that although 44 percent of the cerebral-palsied children were firstborn, many of these represented the mother's only pregnancy. When the mother had more than one pregnancy, the cerebral-palsied child was practically always the one born last or next to last.

The frequency of twins among the cerebral-palsied children was one twin birth per 42.2 pregnancies—more than twice as great as in the population as a whole.

Though most children by the age of 10 have developed hand dominance, that is, have become either righthanded or lefthanded, only about three-fourths of the children studied had developed such dominance at that age. Among these, 46 percent were lefthanded, about four times as many as would be expected in the general population.

Among other recommendations, the report urges further detailed study of the hand functioning of cerebral-palsied children, and much more extensive investigation of their emotional lives.

Price $1.60, less in quantity, from the Council, 1201 Sixteenth Street NW., Washington 6, D. C.

The Family

A report on a 3-year effort to bring "the family" from the "borderline of psychiatric interest" into a specific focus has been issued by the Group for the Advancement of Psychiatry as its Report No. 27, called "Integration and Conflict in Family Behavior." Prepared by Florence R. Kluckhohn and John P. Spiegel for the Group's committee on the family, it tells of the committee's efforts to arrive at generalizations regarding processes within the American family which affect the mental health or illness of its members, and of the conclusions the committee reached.

Since the committee's goal was to examine the totality of the relationships among the members of a family—rather than the effects of one individual on another—it began with a study of the structure and function of the family. However, this led almost immediately to a recognition of variations in family boundaries and functions within the numerous cultural and subcultural groups in this country and to a contemplation of the variations in values within these cultures. Thus, the committee concluded that in order to distinguish conditions in a family which are hostile or conducive to healthy adjustment the social roles of its individual members must be analyzed against the family's own cultural values for the degree of inherent conflict or integration.

In its subsequent analysis of American family patterns the committee found severe strains put upon individuals in the American middle-class family. These it saw as arising from: the weakening of the lineal bond between the generations; a conflict between a kind of childhood training which fosters a strong dependency upon parents and adult expectations of independence and self-reliance; a wedge driven between husband and wife by the enormous amount of time the man must spend away from home and family; the assumption by the mother of a disproportionate portion of moral authority for the whole family; inappropriate training of girls for the wife-mother role.

However, the committee concluded that on the whole the role-system within the American middle-class family "is remarkably well suited to and good preparation for the degrees of freedom and independence which our industrial society calls for."

Copies of the report may be obtained for 50 cents from the Group for the Advancement of Psychiatry, 3617 West Sixth Avenue, Topeka, Kans.

Adoption

Fourteen major social-service organizations, public and private, in New York City, and in two adjacent counties—Westchester and Nassau—have united on an interracial, interfaith basis to form an intensive 3-year project to find permanent homes for Negro and Puerto Rican children. The project, which is called ADOPT-A-CHILD, began operating in mid-January this year. The Field Foundation and the New York Fund for Children have given a total of $49,000 for its support. The Urban League of Greater New York and Westchester County is providing office space for the staff.

The project, which was undertaken in an effort to fill a need estimated to involve some 2,000 Negro and Puerto Rican children in the area, will attempt to develop new methods for finding adoption opportunities for these children as well as to develop community awareness of the problem.

Similar steps are being taken in Chicago, where the Welfare Council of Metropolitan Chicago, with a grant of $25,000 from the Field Foundation, is starting a 2-year project to find adequate adoptive homes for Negro children. According to the Council, more Negro couples would be adopting children now except for widespread misconceptions about requirements, such as the amount of financial security and the age of the adopting couple. The Council reports that at least 100 Negro children are now awaiting adoption at three social agencies.

· · ·

In 1953 about 90,000 adoption petitions were filed in the United States, according to Children's Bureau estimates—80 percent more than were filed in 1944, the date of the Bureau's first national estimate. Slightly more than half the 1953 petitions were filed by persons unrelated to the child. Of the children adopted by nonrelatives, 45 percent were placed in the adoptive homes without the aid of a recognized child-placing agency. The 1953 estimates are based on reports transmitted to the Bureau from 29 State public welfare agencies. The 1944 estimates were derived from reports received directly from 22 such agencies.

Crippled Children

In 1953 as in previous years hospital impatient care and convalescent care for crippled children accounted for a significant part of the expenditures under the State crippled children's programs. Days in hospitals amounted to 1,264,000 in 1953, and in convalescent homes, 469,000.

Two and a half percent more children were given hospital inpatient care than in 1952, but the total number of days in care were 6 percent fewer; in 1953 the average hospital stay was just under a month per child. The decrease continued a downward trend in the average number of hospital days' care that has been taking place over the past decade.

Convalescent-home care was provided for about 10 percent fewer children in 1953 than in 1952, and the total number of days' care was about 3 percent less. In 1953 the average number of days spent by children in convalescent homes was well over 100.

About 203,000 of the children received physicians' services at clinics, 7 percent more than in 1952; 44,000 received such services through home or office visits, also a 7-percent increase.

Altogether services were given under the programs to 251,000 different children during the year, over 5 percent more than in 1952. As in other years about two-fifths of these children were new to the program during the year.

. . .

More and more disabled boys and girls will be prepared for work and placed in gainful employment through an expanded public program of vocational rehabilitation. The services provided include counseling, medical examination, physical restoration, vocational training, job placement, and followup. To carry out this expansion increased Federal funds are available to the States under the 1954 amendments to Federal legislation. The Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, which administers the legislation under which State-Federal services are provided, expects that by 1959 some 40,000 young people 15 to 21 years of age will be rehabilitated each year under the expanded program. This is nearly four times the number of young people rehabilitated annually before the amendments became effective. By 1959 it is estimated that a total of 200,000 disabled persons a year will be rehabilitated.

Among the young people now being prepared for work through these services, boys outnumber girls two to one. In more than half of them the disability is due to disease; in less than one-third it is congenital; in nearly one-fifth it is due to accidents. More than one-third of the youngsters have impairments of the arms or legs or both; leg impairments predominate heavily. Five percent are amputees. Among other types of disability in the young people are visual and hearing impairments, speech disorders, cardiac disease, arrested pulmonary tuberculosis, mental retardation, and epilepsy.

Thirty-eight percent of the disabled persons under 21 years of age are referred to their State rehabilitation agency by schools. Others are referred by doctors, health or crippled children's agencies, hospitals, welfare agencies, and State employment services. Six percent of the young people go to the State agency on their own initiative.

When accepted for vocational-rehabilitation service about 93 percent of the boys and girls are unemployed; 87 percent are dependent on their families.

All the 48 States, the District of Columbia, Alaska, Puerto Rico, and Hawaii operate vocational-rehabilitation programs, usually through their State departments of education.

Blindness

The incidence of blindness among children in the United States has been rising since 1946, according to Dr. Franklin M. Foote, executive director of the National Society for the Prevention of Blindness, in a paper presented at the 1954 interim Congress of the Pan American Association of Ophthalmology. Attributing the rise to an increase in retrolental fibroplasia, an eye condition found in premature babies, he presented data based on medical records of persons under 21 years of age in seven States. This showed that from 1946 to 1950 the rate of blindness per 100,000 had risen from 1.48 per 100,000 to 1.83. Data from 11 States, he said, showed that retrolental fibroplasia caused only 7 percent of the blindness in children under 7 years of age in 1943, but 48 percent in 1950. Nearly 5,000 children in the United States are blind as the result of retrolental fibroplasia, Dr. Foote estimated.

. . .

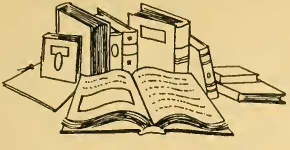
In a fund-raising drive focused on patrons of bowling alleys, a Chicago parents' group, Parents of the Blind, raised $13,000 last October to enable blind children to attend nursery school with sighted children. As of December 5, children were enrolled in nursery schools under the group's scholarships, and 20 to 30 additional scholarships were still available. A child's eligibility for scholarship depends on readiness for nursery school, the availability of a suitable school, and the family's financial need.

Here and There

Kentucky's commissioner of welfare has reorganized the Children's Bureau of the State Department of Welfare. The Bureau now consists of three divisions, covering (1) planning and special services (2) field services, and (3) institutional services. The commissioner abolished two former components of the Bureau, the Division of Youth Authority and the Division of Child Welfare, both of which had operated as separate policy-making bodies.

. . .

The thousands of children 10 years of age and younger in migratory families who are working on crops when they should be in school or at play are a major concern of the National Child Labor Committee, according to the organization's 1954 annual report, "Starting the Second Half Century." Contrary to assertions that child-labor laws are contributing to juvenile delinquency by keeping children idle, the Committee reports that many children are at work today under undesirable conditions. The Committee is also concerned about high-school drop-outs who are not ready for the world of work and ill prepared for the adult responsibilities they will soon be facing.



BOOK NOTES

THE CHILD, HIS PARENTS, AND THE PHYSICIAN. Hale F. Shirley, M. D. Charles C. Thomas, Publisher, Springfield, Ill. 1954. 159 pp. $3.75.

This book for physicians is planned, according to the author, "to present in readily understandable terms basic concepts which are essential to the understanding of the behavior of children and their emotional and social development—concepts which the physician needs every day in his pediatric practice."

After noting several viewpoints commonly held by parents, the author defines the emotional needs of the child, outlines the normal sequence of emotional development, and points out what he calls the "developmental tasks" that the child faces at successive periods. He discusses the various emotional reactions that a child experiences when in conflict with his parents, such as anger and hostility, fear and anxiety, and feelings of inadequacy and guilt.

Describing methods by which a child manages to adapt himself to the requirements of his environment, the author suggests that parents can help in this adaptation by keeping their demands compatible with the child's age, his capacity, and his readiness to respond, and by being flexible and resourceful.

The author describes the bad effects on the child of severe, chronic emotional stress and concludes with suggestions to physicians on how to counsel parents.

SOCIAL SCIENCE IN MEDICINE. Leo W. Simmons and Harold G. Wolff. Russell Sage Foundation, New York. 254 pp. $3.50.

Addressed primarily to students in medicine and the social sciences interested in training for research in these related areas, this book is also intended to be of value to the members of several professional groups, such as medical administrators, educators, public-health officials, social workers, and nurses, who are closely allied with medical specialists in the prevention and treatment of disease.

The authors "construct a frame of reference within which the medical and social sciences can collaborate toward a better understanding of illness." They take the point of view that an individual must be seen simultaneously as an organism, a member of society, and a personality in a culture.

They also discuss links between stress and disease as well as the effect on the patient of stresses caused by hospital practices. Warning against regarding the sociomedical collaboration as "a new magic talisman" providing all the answers, they maintain: "In terms of research, the process must be regarded as an endless one, each new solution giving rise to further problems, which in turn will be subjected to further refinement and further study."

ROBERTS' NUTRITION WORK WITH CHILDREN. Ethel Austin Martin. University of Chicago Press, Chicago. 1954. 527 pp. $7.50.

To take account of the great changes in the field of nutrition in the past 20 years, the author has completely rewritten the authoritative nutrition work first prepared by Lydia Roberts in 1927, and revised by her in 1935.

The first seven chapters set forth the scientific foundation for nutrition work with children. They summarize research findings on nutrition as related to physical growth and development of children, describe methods for appraising nutritional status, state causes and effects of malnutrition, and tell what nutrients are required for attaining and maintaining optimal nutritional status at all stages of growth.

The remaining chapters give an account of the various American and international agencies concerned with nutrition, of the many types of State and local nutrition programs that affect children directly or indirectly, and of nutrition education in the school and the community.

There is an introduction by Dr. Roberts.

POLICE WORK WITH JUVENILES. John P. Kenney and Dan G. Pursuit. Foreword by August Vollmer. Charles C. Thomas, Springfield, Ill. 1954. 371 pp. $7.75.

Written as a guide to law-enforcement departments planning to initiate a juvenile division, or expand an existing one, or reevaluate their total juvenile program, this book, according to the authors, may interest a number of other groups. These are listed as school administrators; social-work administrators; recreation, church, community- organization, and civic leaders; and interested lay persons.

Part 1 covers organization and administration of a police-juvenile program; part 2, individualizing the police approach to juveniles; and part 3, teamwork for delinquency control and prevention. Appendixes give: (a) the names of all graduates of the Delinquency Control Institute, University of Southern California, since the Institute was founded in 1946, as well as of the planning committee and the teaching and research staff; (b) excerpts from a committee report on juvenile traffic offenders in California; (c) an annotated list of films suggested for police juvenile officers; and (d) a bibliography.

THE OPENING DOORS; my child's first eight years without sight. Lois T. Henderson. John Day Co., New York. 1954. 242 pp. $3.50.

In this book a mother tells of her fears, anxieties, and satisfactions as she learned to accept her child's blindness and to open the doors of the seeing world to him. She tells of the help she received from members of her family, teachers, and others, especially a social worker for the blind who is herself sightless.

In the author's own words: "I wanted to tell, as best I could, what it was like for a child born blind, to tell how he learned to adjust himself to a sighted world, and how happiness was there for him if someone took the trouble and the time to curve his small fingers about it."

THE PSYCHOANALYTIC STUDY OF THE CHILD, vol. IX. Ruth S. Eissler and others. International Universities Press, Inc., New York. 1954. 379 pp. $7.50.

The first section of this volume consists of two parts: an abstract of the Freud Memorial Lecture, "Psychoanalysis and Education," delivered by Anna Freud at the New York Academy of Medicine in May 1954, and an account of a discussion, "Problems of Infantile Neurosis," held by the New York Psychoanalytic Society and Institute in the same month. The second section consists of papers on "Problems of Normal and Pathological Development," and the third, on "Technique".

AUDITORY DISORDERS IN CHILDREN; a manual for differential diagnosis. Helmer R. Myklebust. Grune & Stratton, New York. 1954. 367 pp. $6.

A young child's hearing can be evaluated adequately only when it is considered in relation to his total development and behavior, according to this book, which is addressed not only to otolaryngologists and audiologists, but to pediatricians, clinical psychologists, teachers, nurses, and others concerned with children's hearing. Auditory tests are not enough, the author says; a child whose hearing apparatus is normal may seem to be deaf though he is not. He may be emotionally disturbed, or mentally deficient, or unable to talk because of brain damage, a condition known as aphasia. Aphasia is perhaps oftenest confused with actual deafness, says the author.

The book reports that among 228 children referred to a hearing clinic less than half had deficiencies of the hearing mechanism. The rest had auditory disorders due to emotional disturbance, aphasia, or mental deficiency, but special diagnostic methods showed that these children had essentially normal hearing acuity.

The book includes brief general recommendations for helping children in each of the four diagnostic groups, and their parents.

READERS' EXCHANGE

(Continued from page 44)

would expect, however, that of all the changes that have been suggested in the handling of family litigation, this one would arouse the most widespread and determined opposition.

J. D. Hyman
Dean, School of Law, University of Buffalo

HUNT: Handicaps to Study

In her article on "Getting at the Facts of Infant Losses," Dr. Eleanor P. Hunt has stressed the amazing changes in reproductive failure that have taken place in the United States during the last 2 or 3 decades. (CHILDREN, January-February 1955.)

The first phase, namely the reduction of maternal mortality is nearing completion. The second phase, however, that of reduction of perinatal mortality (including fetal deaths and neonatal deaths) appears at the moment to have bogged down into a vital-statistics dilemma. This is brought about by numerous individual classifications and misunderstandings regarding the causes of fetal and neonatal deaths.

In this regard the national and State vital statistics groups have taken the lead as compared to the obstetric and pediatric teaching clinics of the country. In too many teaching clinics the rising birth rate of the last two decades has almost doubled the patient-care problem. Investigation of each and every perinatal death is an expensive procedure in hospital practice, almost out of the price range of the average departmental budget. This fact allows some statistical tabulations, but handicaps thorough biochemical and pathologic investigations, which are so badly needed to understand the scientific mechanisms of infant deaths and in turn their prevention.

Dr. Hunt's article goes a long way in definition of the existing problem and the methods being devised in several population areas of the United States.

George W. Anderson, M. D.
Assistant Professor of Obstetrics, Johns Hopkins University, Baltimore, Md.

HOCHFELD: Migrating Children

As intercounty migration is the chief business of the Intergovernmental Committee for European Migration (ICEM), we were interested to read Eugenie Hochfield's thoughtful article on intercountry adoptions. ("Problems of Intercountry Adoptions," CHILDREN, July–August 1954.)

Since it began operations in 1952, the ICEM has moved close to 300,000 persons from overcrowded countries in Europe to Australia, Canada, the countries of Latin America, the United States, and other overseas lands in a position to receive them. Resettlement of the family as a unit, and reunion of dependents with breadwinners who have preceded them, has meant that many children were included among those whose movement we have assisted.

ICEM is cooperating with the International Social Service and other recognized agencies which aid in the immigration of European orphans to the United States under the Refugee Relief Act. In the case of orphans, ICEM arranges for overseas transportation without the obligation of repayment, as well as for necessary escort service en route, and notifies the agency concerned of the time of the orphan's expected arrival in the United States.

Edward B. Marks
Deputy in Charge of New York Office, Intergovernmental Committee for European Migration

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SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

TRAINING PERSONNEL FOR WORK WITH JUVENILE DELINQUENTS. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, CB Pub. 348. 1954. 90 pp. 35 cents.

This conference report consists of a series of papers with accompanying discussion, on problems involved in preparing more people for work in the delinquency field and in offering training to persons already in the field.

Those whose training needs are dealt with include primarily probation officers, houseparents, and personnel holding social-work positions.

"Next steps" suggested include getting more social-work graduates into the juvenile-delinquency field, improving inservice training programs, and planning special short courses to reach the several thousand workers who need such instruction.

SELECTED CHILD WELFARE EXPENDITURES BY STATE AND LOCAL PUBLIC WELFARE AGENCIES, 1953. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 23. 1954. 16 pp. Single copies available from the Bureau without charge.

The data show that State and local public welfare agencies throughout the Nation spent an estimated $121 million from local, State, and Federal child welfare services funds for child welfare services during the year ended June 30, 1953. This amount was 7.5 percent higher than that for the preceding year.

TENTATIVE STANDARDS FOR TRAINING SCHOOLS. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. 351. 81 pp. 30 cents.

These standards for public institutions for delinquent children, drafted at the request of representatives from two organizations of training schools and revised after a conference between them and the Children's Bureau, are issued in tentative form to give training-school superintendents and others an opportunity to test the material and submit their comments to the Children's Bureau. The standards will then be reissued without the word "tentative," to serve as a general guide, as the foreword says, "in the light of the particular conditions affecting the individual institutions."

Besides discussing a philosophy for training schools, the bulletin covers institutional administration, organization, and maintenance; major aspects of the institution's program; procedures and policies on individual cases; and the child's return to the community.

YOUR PREMATURE BABY. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder 40. 1954. 13 pp. 10 cents.

Parents whose baby is premature and must remain in the hospital for special care will find in this pamphlet answers to some of the questions that parents most commonly ask, such as: Will the baby always be small and weak? Will he be "late" in developing? Will he be normal mentally?

THE ROLE OF THE POLICE IN MENTAL HEALTH. Rhoda J. Milliken. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health. PHS Pub. 360. 1954. 5 pp. 5 cents.

This booklet offers an interpretation for police officers of why they need to understand children, with a list of source material to help them in this direction.

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Closely identified with Illinois' program for parents of preschool blind children ever since its transfer to the Division of Child Welfare, Lela B. Carr rounds out this year a decade of service with that Division in the Illinois Department of Public Welfare. Prior to that she worked for several years in private family agencies at Decatur and Rockford, Ill., and supervised students in a psychiatric unit for 2 years at the University of Chicago Clinics. She is a graduate of the School of Social Service Administration, Chicago.

A graduate in home economics from Iowa State College, Ruth B. Hayes, left, has also had training in social work at the New York School of Social Work. She was consultant for 9 years to public health nurses and caseworkers of the Community Service Society, New York City. Her co-author, Muriel F. Steeves, had extensive experience in the public welfare field in New York State before going to Westchester County in 1946. Her M. A. is from the New York School.

Nationally known for his pioneer work in rehabilitation programs of the "team design," in which medical and nonmedical services are integrated and coordinated, Dr. Baker has established public and private programs for handicapped children in many States. A Fellow and Past President of the American Speech and Hearing Association, he is also the author of an outstanding text in this field, *The Handbook of Clinical Speech*, and is a Professor of Clinical Speech Pathology in the University of Illinois College of Medicine. His hobby, he says, is falconry.

"Just as a light touch on the rudder will swing a floundering boat back onto course, so a small, skillfully directed force can work wonders in stabilizing a distraught family. One such force is Vincentz Cianci (pronounced 'Chauncey')." This is the way the *Saturday Evening Post* introduced Miss Cianci to its readers. Trained in education, psychology, and social work, she was chosen to launch New Jersey's home training program in 1943. She was a delegate from the American Association on Mental Deficiency in 1949 to the World Mental Health Conference.

Reaching the difficult-to-reach young delinquent has been a major concern of Ralph W. Whelan during many of his professional years. Shortly after obtaining his Masters in social work from Boston College School of Social Work, he worked as research assistant to the Glueck Research Program, Harvard Law School. This was followed by 3 years as executive director of the Youth Counseling Service of the Archdiocese of New York, before assuming his present position which is attached to the Office of the Mayor.

frontispiece

SOME WORKERS, like parents, regard blindness as something so very different that they do not know what to do, Lela B. Carr observes in her article in this issue. A 2-day institute, at which specialists discussed the problems of blind children and their parents, gave new confidence to child welfare workers in Illinois that their casework skills were as usable and needed with this group as with any family struggling with a serious situation. Designing and giving services for blind children presents fewer problems when both are built on the basic principle that these children need the same things all children need and should be helped to grow up as much like other children as possible.

—LIFE Photo by Francis Miller.

Child welfare workers head up a statewide program of services to . . .

PRESCHOOL BLIND CHILDREN AND THEIR PARENTS

LELA B. CARR, M. A.

Assistant Superintendent, Division of Child Welfare, Illinois Department of Public Welfare

HOW CAN I teach my blind baby to eat solid foods? Will he be able to get through school? Will he have to associate only with other blind people? How can he make friends? How will he earn a living?

These and many other questions face the parents of blind children. And beneath them often lies the unasked, tormenting question: "What have I done to bring this about?"

Such questions spring normally from a parent's reaction to his child's blindness, but they call for expert help not only in making available more information about blindness, a blind child's needs, and ways of meeting them, but also in coping with the emotional problems that underlie and accompany them. The sooner such help is proffered to the mother and father of a blind child the more likely are they to be able to help their child develop to the fullest his capacities as a human being.

In Illinois a growing realization of this need has been behind the development of a comprehensive program for pre-school blind children and their parents in which the Department of Public Welfare plays a prominent role, along with a number of other agencies, both public and private.

The program got underway back in 1946. That year the department, through its division for the blind, initiated a demonstration project which provided a home counselor for parents of pre-school blind children in Chicago. Cooperating with the division in the establishment of the program were the department's division of child welfare, the Chicago Public Schools, the State Commission for Handicapped Children, Illinois Public Aid Commission, the Division of Child Welfare, Chicago Council of Social Agencies, and the University of Chicago Eye Clinics. Some of the same agencies, and a few others, were also involved that same year in planning and conducting an institute for parents of pre-school blind children held at the State School for the Blind, the first one of a series of institutes which is still going on.

Simultaneously, the Department of Ophthalmology of the University of Chicago Clinics, with the cooperation of medical staff and the Departments of Psychology and Social Service of the Clinics, was engaged in a special project to study the problem of the adjustment of blind children and their families to permanent blindness. This project had been prompted by recognition of the increasing incidence of blindness in children caused by retrolental fibroplasia, an eye condition associated with prematurity the cause of which was not then known.[1]

All the agencies cooperating in these programs have worked on the theory that a blind child should be given opportunities to live as normal a life as possible. Their joint objectives have been to locate preschool blind children and to make what services they need available on a statewide basis.

In 1949, the department's project advanced from a "demonstration" to a permanent program and, in accordance with the basic philosophy that blind children are first of all children with the same needs that other children have, was administratively transferred from the division for the blind to the division of child welfare, with child welfare workers carrying responsibility for providing the counseling services in various parts of the State.

A 2-day institute was held at the time of transfer to provide child-welfare workers relevant information regarding blindness and blind children. Representatives of the agencies that had initiated the program discussed casework skills, the education and home training of the child, teaching parents how to do the training, and current knowledge on blindness and blind people and the problems of being blind.

Counseling Service

From the beginning the counseling experience has pointed up certain basic principles of the casework process: the importance of beginning with the parents where they are, in this instance in a state of fear, anxiety, and often defeatism; educating through the provision of information; helping through relationship; enlisting interest through interpretation; making use of available community resources.

As in all casework effort, the experience has met with varying degrees of progress in individual situations. There have been success stories, like the following:

> Bobbie's parents could not accept their baby's blindness. Until he was two, they clung to the hope that his eye condition would improve. By that time, however, their anxiety was increasing because they realized that he was retarded in comparison with other children of his age. In spite of Bobbie's inability to do many things that would be expected normally of a 2-year-old, the counselor observed that he seemed to be intelligent and alert.
>
> Although the mother had not given up hope that Bobbie would have some sight, she said she knew that she and the father could not wait until he could see to begin his training. She knew that they should have done more than they had. She asked what kind of toys should be provided for a blind child but seemed unconvinced when told there were no special toys needed and only a few toys had to be eliminated from his experience. The counselor spent some time in discussing the use of toys, pointing out that the blind child might need considerably more help than the sighted child in learning how to use them and that this required some body manipulation by the parents. Bobbie's mother then asked about educational facilities, implying that she did not understand at all how a blind child could be educated. The counselor told her of the educational facilities which existed in the city and of the State residential school.
>
> This mother had only vaguely heard about Braille and was thrilled when the counselor told her about it in detail. To give her a feeling of greater encouragement for the future the counselor told her about some educational devices, such as raised relief maps, Braille music, Braille typewriters, the use of regular standard typewriters and other educational means. The counselor also pointed out that many children go to regular nursery school with sighted children when they are 3 years old or a little older, but the mother found considerable difficulty in accepting this possibility.
>
> It was hard for this mother to let the interview end. She was most eager for a definite return appointment and since the counselor felt that this was an intelligent approach and that the mother seemed ready to use services, an appointment was given her for 2 weeks hence.

The counselor continued interviews with Bobbie's mother on a regular basis. During those the mother brought out more of her feelings of wanting to do everything she could for Bobbie but of deep disappointment in having a blind child and resentment over the extra responsibilities. The process of helping her reach the stage where she could give Bobbie more freedom to move about and explore, of helping her understand her hostility and the resultant guilt when she disciplined him, of encouraging her to take some time off from caring for Bobbie for herself, and of helping her gain an understanding of the uses she could make of the interview situation, involved skillful use of relationship and the authority of knowledge about the handicap of blindness.

Institutes for Parents

As a supplement to the counseling program and in line with the proposals in the cooperating agencies' statewide plan, the program has involved the development of annual summer institutes for the parents of pre-school blind children, held at the State School for the Blind, now called the Illinois Braille and Sight Saving School. These provide parents from all parts of the State with the opportunity not only to receive information on different aspects of child care and development, but also to participate in group discussions with others who are facing experiences and problems similar to their own.

Certain features have characterized the planning and conducting of the nine annual institutes which have thus far been held. An advisory and planning committee has enlisted the cooperation and support of a number of public and private organizations interested in services to parents and their blind children. These have shared a large degree of responsibility, in case finding, financial assistance, loan of specialized staff, or consultation service. Provision has been made for the attendance of children as well as parents. The institute program through the years has been organized to give information about many phases of child development and blindness in its medical, social, educational, and personal aspects. Increasing opportunity has been given parents attending the institute to have individual conferences with consultants, social workers, and teachers.

Each year the staff and planning committees have evaluated the institute, and parents have been asked to make suggestions for changes that would increase its value to them. These evaluations have resulted in changes in emphasis but the purposes have not changed since they were clearly and fully stated by the original planning group.

The experience of the first institute, held August 25–30, 1946, produced recommendations which have given direction to succeeding institutes ever since. This showed the need for more medical and social information for providing help to individual mothers; a comprehensive plan of orientation for all participating staff; staff meetings during the institute so that indicated changes in program could be made and emerging problems handled; more opportunities for the children to have outdoor play involving large muscle activities; a weekend session to provide fathers with an opportunity to attend at least part of the institute.

Fathers have attended in increasing numbers since the first institute, although some of them could be present only over the weekend. Other members of the family group, important to the child, have been invited in particular instances. They have included grandmothers, aunts, sighted siblings and foster parents. Parents whose children are too young to be brought along have also been encouraged to attend.

While the lecture method was employed in the beginning, in recent years the program has been developed around the workshop method with three or four groups of parents led by a child welfare worker or a nursery school teacher.

One significant value in having the children attend is the opportunity it gives parents to observe blind children other than their own and to see the reactions of the children to opportunities for achievement provided in an enriched nursery school program under the leadership of qualified professional staff. Some children walk alone for the first time; others hold their own glass of fruit juice; some ride a tricycle or dare to use the slide. Parents are usually able to allow their children more freedom after they return home. The institute's nursery school also helps parents and children to experience separation under desirable conditions, for many, their first separation. It also affords an excellent opportunity for staff to determine the child's stage of development and to evaluate his capacity to make progress, so that they can give help to the parents and whatever agencies are working with them.

COMMUNITY, as well as parental, attitudes toward blindness are extremely important to a child's adjustment. The caseworker's skill in cultivating healthy community attitudes can help the blind child relate to normal society in a mature way.

A toy shop developed from ideas given by a consultant on toys at a general meeting has become an established part of the institute and attracts parents, staff, and visitors like a magnet. Many fathers and some mothers get pleasure out of operating the power machinery under the guidance and direction of the School's manual training teacher. They take pride in the chairs, tables, hobby-horses, building blocks, easels, wooden animals, and numerous other items they make.

The institute provides new and stimulating experiences for both parents and children. Last year, the pediatrician stayed with the group 2 hours after her formal talk to answer questions. The ophthalmologist had the same experience after explaining the structure and care of the eyes. Parents of even the youngest children want to know how their children can be educated and a special meeting is devoted to facilities and resources for education. Many apply themselves with great intensity to learn Braille. On one occasion, when a mother asked if she should

RELATIONSHIPS between parents and a blind child can be as healthy as those with a physically normal child, but blindness can impose a strain on both. The caseworker's skill in helping to strengthen these relationships is invaluable.

teach Braille to her child, the teacher suggested that she "help him to be ready to learn Braille," by teaching him the meaning of "top" and "bottom" of a page—an essential concept in Braille, but extremely difficult for a blind child to grasp.

Informally, parents talk long hours with two consultants who are themselves blind. Parents want to know what it is like to be blind. Their questions relate to almost every aspect of living. They want to know what the future holds for their blind children. The approach used with them is that blindness, although a sensory limitation, does not prevent happy, useful living and attaining accomplishments that can be a source of gratification and pride.

Not the least of advantages for some parents, is the opportunity to have a vacation in an expanse of grass and trees, with excellent free meals, an hour each day in the swimming pool with their children, an evening of stunts and games or dancing, and time to sit on the lawn and visit.

Over the years, gains in knowledge and understanding, changes in program, and swelling attendance have demanded steady increases in staff from various professional disciplines. The first institute was attended by 21 mothers and 20 children. The 1954 institute was attended by 32 parents without children and 24 parents with 15 children, the 56 parents present representing 36 blind children.

In 1946 the salary of the first home counselor was paid from private funds. Housing and board of staff, parents, and children were provided by the State School for the Blind at the first and all succeeding institutes. The staff was loaned by sponsoring agencies. Since 1950 additional staff, travel costs of staff to and from the institute, and materials have been provided through Federal Child Welfare Services funds and have amounted to approximately $3,000 per year. These funds also cover the salary of two child welfare workers in the Chicago area where the number of families receiving service warrant specialized caseloads. They also cover nursery school fees for children whose parents cannot pay tuition.

Use of Nursery Schools

Nursery schools that have been willing to admit a blind child to their groups of sighted children are making an inestimable contribution to the development of these children. Here is a teacher's story of what a nursery school did for Jimmy who feared new objects and all children.

> It was my view that adults to him may have been strange, wonderful beings who could do marvelous things that Jimmy could not do, and he was aware of his dependence on them for the things he could not do for himself. Moreover, they centered a great deal of attention on him, gave him undue consideration, so that though he could not see them he could feel like a king with others bowing down to him, anxious to please him.
>
> Children, however, were different to him. Not only did he not know how to respond to them but they represented a complete threat to his security. How is one to explain children who can see and do things that Jimmy cannot do? How is one to teach cooperation and living with others to a child who has no conception of others and is so completely self-centered that other children do not exist in his mind?
>
> Jimmy's eagerness and his enthusiasm for nursery school were always encouraging signs. He soon outgrew the experience of going up and down the slide and was ready for new experience—the swings, the barrels, the chicken coop, and the walking boards. At the very beginning he would express strong desire to go on the swing; after sitting down on the seat he would ask to be removed. There was no strong expression of fears; there was rather an expression of insecurity as if he did not know what to expect but would not wait to find out. From time to time I brought him back to the swings. Then after a week had passed, he finally consented to be pushed. For a moment he was frightened but as I held

him, his fear changed to genuine enjoyment. I sang a song about a swing as I pushed him up into the air and for weeks afterwards he associated the swing with the song.

I attempted, too, to introduce Jimmy to some aspects of routine, but during the first month I made no attempt to have him become a part of the group. It was always difficult to keep him seated for any length of time. Because his interest span was limited I spent a tremendous amount of time trying to channelize his energy. Around and around the room he went, touching this thing and that, up the stairs and out of the door of the playroom leading to the staircase in the building.

At first everyone expected Jimmy to have special privileges, especially since we were trying to cultivate his interests to a point where they would be more sustaining. However, as I became more familiar with his behavior I felt it would be necessary to have him become aware of the fact that there were children about him who were also interested in the things that appealed to him. Until we introduced the idea of sharing his toys or giving up the swing to another child he generally stayed out of the other children's way or would make sure that they were not in his way by pushing them aside quite vigorously.

As Jimmy persisted in his aggressive behavior, I told him that if he pushed the children he might get pushed back. At this particular time I felt that he was quite ready for this kind of control, that in order to learn his relationship to others about him, he must learn it in a perfectly normal fashion as any other child would learn. In no other way could he gauge the reactions of those about him. Moreover there was no other way through which he could establish his standards of value of what one can do and what one cannot do.

We decided, therefore, to treat Jimmy as we would any other child. However, we began this gradually so that his sense of frustration at the very beginning would not be too intense. Jimmy responded very well. He did not react strongly to waiting like the others for a turn on the swing or to giving up the bicycle after he had had it for quite a while, though like most of our sighted children he was impatient at first about having to wait his turn. Soon Jimmy was sent out on the playground with the other children and although he still received some individual attention he began to acquire a degree of independence.

Toilet routines particularly began to reveal Jimmy's increased confidence in being able to do things for himself. He loved to wash his hands and to splash about in the water. With encouragement he became able to pull up and adjust his clothing, though he showed some reticence at first, saying "I can't, you do it." When we could convince him that what we demanded of him was a relatively easy task, he found that he was able to accomplish the job.

Jimmy was able to manipulate the hot and cold water faucets within a short period of time and to reach around the basin to find the soap. He also took pride in finding his own paper towel. Often he would grope about the wall for some time but when I offered assistance he would refuse, saying he wanted to find it himself. He became able to locate the wastebasket and would drop his towel inside when he had finished drying his hands just as the other children did.

SOME 5,800 children under 7 years of age, or 1 in every 4,000, it is estimated, are blind. In the school-age group, the total is some 6,600 or 1 in every 5,000. Many are in residential schools; only a few are in special public school classes.

It is not possible to include all the exciting details of the process through which the teacher helped Jimmy learn to do things for himself. In her record she concluded:

> Gradually, I found it necessary to spend less and less time with Jimmy. As he no longer needed my presence so greatly, I turned him over to the other teachers and the children in his group. By degrees he became increasingly independent and soon we found ourselves regarding him as any other child. He was able to manage himself as well as any child, running about, trying out the toys, going up to the slide and riding in the swing. It was not long before he was entering into all activities with the other children.

Jimmy's development is an illustration of the kind of contribution that a number of nursery schools are making in accepting a blind child with sighted children.

Parents' Groups

The participation of child welfare staff in parents' groups has varied in different sections of the State. The Parents of the Blind in Chicago, established several years ago, is an active, forward-looking group organized by the parents in an effort to help one another. The group undertakes numerous projects including publication of a monthly, *The Outlook*, which provides the membership with information and the opportunity to exchange ideas. The parents assume leadership and responsibility although the child-welfare workers attend meetings as interested participants.

Another parents' group, in Peoria, operates a day camp during the summer and for the past 2 years has employed child-welfare workers, formerly on the State staff, as camp directors.

In the Carbondale area the department's child welfare staff took leadership in organizing and guiding a parents' group. While several meetings were held over the period of a year, attendance remained low because of travel difficulties, and the group eventually disbanded. Similarly a parents' group organized in East St. Louis under the joint sponsorship of the Family Service Association of Alton and the Department of Public Welfare regional office lapsed after a series of meetings in which the parents seemed to find a good deal of release in talking with each other about their difficulties. Just as parents become less dependent on individual counseling as they gain security, their need for institutes and parents' groups declines as their confidence grows.

The experience since 1946 has revealed four major facts about services to parents of preschool blind children: 1) These parents have real anxieties around the handicap of blindness, requiring special help; 2) effective methods of providing service include individual casework counseling and group counseling; 3) skilled workers are needed with special knowledge, understanding, and motivation, to carry on the services; 4) the achievement of objectives in providing service is also related to a service conviction.

The Department of Public Welfare still faces many problems in providing more effective service to these parents. The amount and quality of casework service given by the agency is not uniform throughout the State. While there seems to be an advantage in assigning all such cases within a given region to one worker because of the special knowledge about blindness the work requires, this practice is not realistic in rural areas where families live great distances apart. Outstanding work has been done occasionally by workers with only one or two preschool blind cases in a mixed caseload, but too often "case closed, family did not want service" has been the only result.

Actually, the agency has not succeeded with all staff in stimulating interest, concern, and a sense of responsibility for this service. Some workers, like the parents, regard blindness as something so very different that they do not know what to do. Despite these problems, the agency must continue to ask itself whether it is truly answering the parents' questions: Can I or anyone else really teach my child? Can he lead a normal life? Why has this happened to my family? The challenge to the agency is to find and give the right and honest answers to each individual.

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[1] Norris, Miriam: Some Social Problems Presented by the Increasing Incidence of Blindness Among Children. Paper presented at Medical Women's Association Breakfast, Annual Meeting, Illinois State Medical Society, May 1949.

The personality of the child, in which memory plays so vital a part, requires protection even more than his physical health and mental development. It has become a trite saying that children need security. They need to have a sense of belonging—of being important to someone and of having a share in the things that pertain to their small world. It is not alone freedom from want that is implied, but security in the affection of those who are responsible for his upbringing, and protection of his rights as a personality. Perhaps another thought should be added to the expanding philosophy of the rights of children: childhood is important in itself; it is not only a period of preparation for life as an adult and as a citizen. Children as children have certain inalienable rights. . . .

EMMA OCTAVIA LUNDBERG, 1881–1955

"Unto the Least of These," D. Appleton-Century Co., 1947

Caseworkers gain new insights in sharing in the development of . . .

ALLOWANCES IN FOSTER CARE

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A LITTLE OVER A YEAR AGO the Westchester County, N. Y., foster care program met with a misfortune. But it was a misfortune that the Department of Family and Child Welfare in the county welfare department almost immediately turned to account. The unhappy occurrence was the withdrawal of funds for personal allowances to children, previously provided the department by a voluntary agency. The results were rethinking by staff of the whole picture of money paid to foster families for the care of normal children and renewed staff appreciation of the meaning of money in the casework process.

The review came about when the County Board of Supervisors agreed that personal allowances for children could be provided from county funds. This led to the question of whether the present board rates were sufficient to cover such allowances, and inevitably to the more basic question of what board rates were intended to provide. Faced with these questions the department's administrative staff saw not only an administrative problem but also an opportunity for staff development. Back in 1947, staff participation in the establishment of clothing replacement and wardrobe standards had demonstrated the value of such a procedure.

After several conferences of supervisors and administrator the agency reached a plan for staff participation in a review of policies. This involved the establishment of three workshops, each with one of the following assignments:

1. To determine a base for a personal spending allowance for children in foster care as well as policies for its administration and to develop policy guides for the use of children's earnings.
2. To review and restudy clothing standards and allowances, as well as policies for administering clothing to foster home children.
3. To determine the amount of money necessary and the items of living included in the board payment to foster parents.

The supervisor of training and the home economist attended all meetings, acting as joint leaders of the group, and thus providing a blending of casework and home economics concepts.

Each workshop called for six social caseworkers and two to three supervisors, all of whom volunteered for the assignments. They met for 2 hours every other week for a period of 3 months. The leaders reported periodically on the groups' goals and directions to the director and senior case supervisor for evaluation and approval. They also reported to each group about the others' progress and thinking whenever this was relevant to the discussion.

The Reference Family

Because of the importance of using objective methods in developing allowance standards and allowances, the home economist presented the group with information about actual family living patterns derived from research. As the discussions developed she helped the members of each group to see that, within any family, living patterns are developed through planning, coordinating, controlling, guiding, directing, and evaluating family goals, and that since no two families have the same degree of resources nor the same goals, family patterns, and therefore needs and expenditures, vary. However, she explained that in order to focus the three workshops for overall planning a money expenditure pattern for a "reference foster family" had to be established.

This involved the work groups in discovering the characteristics of the county's typical foster family—its nationality background, its size and makeup, the type of community and housing it lived in, the age-range of the foster parents, the father's occupation, the monthly income, and other resources. With the help of the home economist, the groups found most of the answers in a study of foster parents which had been prepared by social work students doing their field work in the department, and from additional studies carried on by the groups themselves.

They found Westchester's "typical" foster family to be a family of four with an income of $3,700, living in a one- or two-family house or an apartment in a suburban area; one or both of the two children were foster children; the two parents were between the ages of 40 and 50; with the father engaged in a skilled occupation in the manufacturing, transportation, or communication fields.

Since no information existed on which to form a composite picture of the foster family's expenditures, the groups had to assume that the typical foster family followed an expenditure pattern similar to the pattern of the family of the average wage earner in New York City on which figures were available from the U. S. Department of Labor.[1] This showed a family of three with an income of $4,248 spending its income in 1950 in the following approximate proportions: 34 percent for food—in and out of the home; 13 percent for clothing; 12 percent for housing; 8 percent for transportation; 6 percent for house furnishing and equipment; 5 percent for household operations; 5 percent for medical care; 5 percent for recreation; 3 percent for fuel, light, refrigeration and water; 2 percent for personal care; 1 percent for education; 1 percent for reading; 5 percent for miscellaneous.

In adopting this pattern as a basis for their measurements of money allotments, the workshop members repeatedly expressed their awareness that no two foster families could be expected to follow the same expenditure patterns and that the concept of a median or "reference family" was useful only for broad policy planning purposes. They asked for and received constant reassurance that such broad policy planning would not prevent or seriously impair the individualized treatment essential in working with children. They agreed that if board rates and other allowances were to remain realistic the income level of foster families would have to be reviewed periodically in relation to costs and spending patterns.

The groups focused on the reference family's total needs and the proportion of these that could be regarded as a burden imposed by the presence of the foster child, and hence the agency's responsibility. From the beginning the discussions moved on the assumption that the agency would meet expenditures for the child's clothing, medical expenses, and personal spending in addition to the board payments, since this pattern had already proven its value to the caseworker in helping the foster parents train the child.

Board Rate Workshop

Because of a reluctance to talk about money, members of the board rate workshop experienced some difficulty in getting to the core of their problem. They first had to unshackle themselves from the idea, still prevalent in the child welfare field, that considering the money value of the foster home board rate seems like putting a price on "the love of children." This block had for some time been evident in agency records.

As the workshop progressed, however, the participants agreed that child welfare practice had become strengthened as caseworkers became convinced, through experience, that they could help foster parents become "better parents" by realistically facing the subject of money. However, when they confronted the question "what are we paying foster mothers for in our present board rate?" they had to answer, "We do not know." In reviewing agency policy they found the board rate had been established as a token of recognition of foster families' out-of-pocket expenses and had gradually been increased under pressure of rising costs of living, complaints of foster parents, and competition between agencies for foster families. At the time of the discussions the rate was $60 a month for a child under

2 years old; $55 for a child between 2 and 13; $60 for a child 13 years of age or over.

To help the group determine the adequacy of these rates the home economist asked the members to list all the items a foster family must pay to provide for the child's physical needs, thus revealing the need for a reference foster family. Using the New York average wage earner's expenditure pattern, with the group's help she worked out the proportionate shares of the $3,700 income of the county's "typical" foster home family. Excluding expenditures for clothing and medical care, the foster child's share came to $720, or $60 a month.

Considerable care went into this prorating, which involved determining a child's share of eleven items of a household's expenditure. In considering transportation, for instance, the group decided that since this item was tied in with the foster parents' recreation and work, only 50 percent of it could be considered a family affair and so be subject to prorating.

The caseworkers reacted with both surprise and skepticism when the child's portion of family expenditures turned out to be so close to the actual board rate. Their discussion revealed, however, that the analysis had broadened their point of view about the usefulness of the board payment. They talked about the times they had become defensive when a foster mother complained about not being paid for "wornout sheets or broken furniture" and about their inability to answer such a challenge because they had no information on which to draw. They expressed enthusiasm over having a new tool to help them in arriving at an understanding of all the motivations of foster families in requesting and keeping children; and suggested that having it at hand would help them to be more frank and at ease in sorting out with foster families the realities of the costs and other problems of caring for children.

During the discussions the question arose as to why the agency paid different board rates for children of different ages. They found two reasons: differences in the amount of responsibility involved in the child's care and in the amount of food the child would require. The home economist illustrated the latter point by preparing a food standard based on a consumption pattern for a moderate-income family. In these costs she included amounts for food consumed out of the home. This total was then added to the costs of the other ten items to get the total amount required for the care of a child in each of several age groups. Past experiences led to limiting the age groups to three. The cost, with the food differential, was calculated to be $48 for a child under two, $55 for a child from 2 to 13 years, and $62 for a child 13 years and over.

PAYMENT of a "service token" to foster parents, to symbolize the community's appreciation for the time, care, and affection they give their charges, became an accepted element in the allowances made by the county welfare department.

Service Payment

Next the board rate workshop faced an important question: whether the board rate should or does include payment for services rendered. This involved the related question of whether foster families expect to make a monetary profit in boarding children. Thus the group began to consider the inclusion of a "service item" in the board rate. In recognizing that the agency already paid some foster parents for service by allowing a higher board rate for children with special needs and problems, the group arrived at the opinion that all foster parents should be paid for their services to children. But could the agency afford it?

Here again the home economist provided some factual data from an unpublished study of urban homemakers' use of time with children of different ages. This showed that the proportion of time mothers spent caring for their children decreased from 20 percent for children aged 2 and under, to 2 percent for children between 10 and 14 years. Concerned over the scarcity of foster homes for very young children and with this study as a guide, workshop participants carefully computed what it would cost to pay foster mothers for the time spent in a young child's care. Finding that at the minimum wage rate of 75 cents per hour the service item alone would come to $70.95 a month, they reluctantly concluded that the agency never could pay for actual services rendered.

With encouragement from the home economist, the workgroup considered the value of a token payment for service, deciding that to include such an item in the board rate would be a step forward. They accepted a suggestion of a "service token" of 25 percent over the total cost of basic items estimated for children under 2, and 5 percent for all other normal children in foster home care. To add such a service item to a board rate arrived at through the foregoing procedures would mean that the board rate for children under 2 would remain at $60 a month, and would be increased to $57 for children 2 to 13 and to $65 for children over 13. Application of these new board rates would increase the agency's total budget by 2 or 3 percent.

Toward the end of the discussions the term "board rate" gave way to "foster home allowance" as more appropriate to a payment that covered a share of all expenses in the home, except medical care and clothing, plus a token recognition of service. Any future bargaining done on the basis of how much of themselves foster parents are willing to give for the rewards of having a child around, the caseworkers felt should concern the service token only rather than the allowance as a whole.

At the end of their sixth session the members of the group expressed the feeling that they had not only provided the staff and administration with a sound approach for determining foster home allowances and keeping them on a current cost basis but had provided themselves with more assurance for considering the material needs of the foster child in the future.

Personal Allowances

The group concentrating on personal allowances considered children's need for money for gifts and for satisfying individual desires. Using the same reference family formula chosen by the workshop on board rates these participants found that foster parents would spend about 6½ percent of their income for items involved in recreation. Some of this, the group decided, could justifiably come out of the board payment since foster children can share in the family's recreational activities; some, however, should come out of the child's personal allowance. While this allowance in a normal family would be made from the family income, the participants agreed that in a foster family it would best come from the Department of Welfare, and reach the child through the foster parents, because of the department's joint responsibility with the family for helping the child learn to use money.

The group put school expenses first in the items to be covered in a personal allowance. Recognizing that schools vary greatly in their financial demands on children, the participants proceeded to make a study of school expenses, requesting the help of the superintendents and supervising principals of 50 percent of the county's elementary, junior and senior high schools. Those that agreed to help were asked to list the items children needed to spend money on and to estimate the cost. If 50 percent of the participating schools indicated that the majority of their children spent money for a specific item the workgroup accepted this as an essential school expense and itemized it at the median of the various costs estimated by the schools. Needs and costs varied among school grades as well as among the different schools.

Many questions arose within the group as the participants analyzed the ingredients of the school expense item. Should transportation costs to and from school come from the child's own allowance, from the foster home allowance, or from the school? What about school lunches, afternoon milk, gym apparel? Should child or foster family be responsible for haircuts, dry cleaning, shoe repair, movies, ice cream, or church contributions?

After several meetings the group came to the following decisions:

The foster home allowance should be expected to cover the expenses of haircuts, all food including that eaten outside the home, all group family recreation, including church activities and movies. Transportation should also come out of the foster home allowance, except for expenses of an unusual nature which would be taken care of by the agency on an "as needed and approved" basis. All clothing, except for special items such as graduation gowns or scout uniforms should come out of the clothing allowance.

Next to school expenses the workshop considered the expense of the child of engaging in group activities. The group chose scouting, one of the most popular activities in Westchester County, as the norm

PERSONAL allowances for all school children in foster care were rated essential because of their usefulness in giving these children a sense of status among their fellows, and in helping them learn the necessity of making choices in their spending.

for estimating the cost of this item at three different school-age levels.

The workshop also allowed for a "miscellaneous" item in estimating a child's personal expenses. Since no data were available on what this might include, the group set arbitrary figures for children at different school levels, adding them to the estimates of school expenses and group activities to arrive at the following allowances: 45 cents a month for children in the first and second grades; 75 cents a month for other elementary school children; $1.15 for children in junior high school; and $2.35 for high school students.

While the total cost to the department of such disbursements would be considerably more than the amount of money that had been received from the voluntary agency for personal allowances, the workshop participants stuck to the recommendation of personal allowances for all school children in foster care because of their usefulness in teaching children the value of money and the necessity of making choices, and also because of the sense of status that having money can give to a child. Members of the group pointed out that when the prestige value of money is used positively it can add to an individual's feeling of worth.

This workshop is continuing to meet in order to consider the subject of children's earnings and ways of helping children learn how to use them.

The workshop on clothing standards and allowances reviewed the policies established in 1947 in the light of current consumer buying studies. Applying this information to the foster reference family, and studying other expenditure patterns for different age, sex and activity, the group arrived at the same percentage expenditure on replacement clothing for a family of four as in the expenditure pattern of the New York wage earner's family. Emphasis was placed on the adequacy of the basic clothing wardrobe at time of placement as this affects the validity of the replacement allowance. After considering these factors, the group recommended an increase of 7 percent over allowances in effect.

Throughout the workshop its leaders stressed the importance of allowing children to participate in planning for their clothing purchases, the home economist emphasized the value of training children in clothing selection and management; and the training supervisor pointed up the opportunities for children to learn about family sharing. Becoming aware of their need for more detailed information, the workshop participants asked the department to issue leaflets for use with foster parents in making individual decisions on clothing.

The Results

All three workshops resulted in revisions in the department's policies in regard to payments to foster families, bringing board rates and allowances into a more realistic alignment with their purposes. The workshops also proved fruitful to staff itself for they brought about a wider and deeper understanding on the part of the caseworker of the material needs of both foster family and child, the relation of these to emotional needs, and the use the caseworker can make of this understanding in her day to day job.

Moreover, the experience also brought about an increase in interprofessional understanding by creating greater mutual appreciation between home economist and social caseworker of the purposes and methods of each and of the interrelatedness of their responsibilities.

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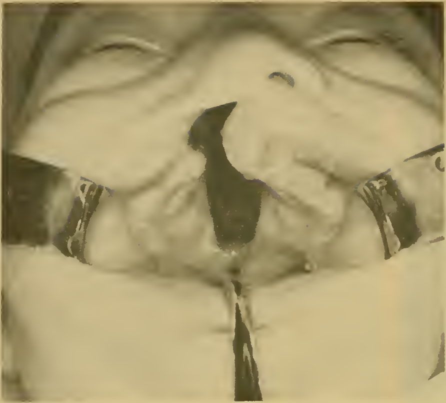
[1] Bureau of Labor Statistics, U. S. Department of Labor: Family Income, Expenditures, and Savings in 1950. Preliminary Report (Revised). June 1953. Bulletin 1097. Washington, D. C.: U. S. Government Printing Office, 1953. 66 pp. 40 cents.



CLEFT PALATE HABILITATION—PRESENT TENSE

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A BRIGHT, NEW TERM is ascendant in our professional vocabulary. Wherever specialists gather to discuss enterprise, one may expect an early allusion to "the team." It is an advertisement of a still larger movement in pure and applied science—a movement which has been labelled in various places at various times as cooperation, collaboration, group enterprise, effort integration, and teamwork.

The increasing complexity of knowledges and the urgencies of their effective application have directed many persons in many areas to seek a redintegration—a synthesis—to reestablish a quality of wholeism where there had been fractionation. Ollie Backus, a distinguished American speech pathologist, expressed this accurately when she wrote: "In an era when the dominant orientation was directed to specialization, boundary relationships between various fields were conceived of as lines in the sense of barriers. Professional preparation of students stayed quite largely within the lines as defined by each field. Then when those students entered professional practice, they tended to continue to operate within such lines."[1] The dentist limited himself to the teeth and their investing tissues; the surgeon to the manipulation of tissue elsewhere in the body; the cardiologist to the heart and circulovascular system; the psychologist and the psychiatrist to normal and pathological behavior; the teacher to the educative processes; the speech pathologist to disorders of speech and language; and the otolaryngologist to the head spaces, and so on.

The impetus of war and readjustments of peacetime economies and sociologies have caused the evolution of research and industrial production teams now most frequently seen in the fields of nuclear energy and electronics. In the service fields of human welfare, teams are also evolving and are developing techniques for habilitation and rehabilitation, and for the improvement and extension of life. In a more recent development the multi-disciplinary group is being used as an instrument of instruction to augment the classical single-teacher didactic structure.

The team is also being applied in clinical areas. As in education, the growth of the clinical team has been less impressive and less rapid than that of research-and-production teams of science and of industry.

The Team Function

It is reasonable to inquire what special advantages and values accrue from the team function. Is there not common agreement that the search for scientific truth and the clinical processes are uniquely individualistic? At their best, are they not characterized by the individual functioning in a climate of isolation, or, in the case of the clinician, in the strictly bilateral inter-personal relationship between the clinician and his patient? Is not the complexity of the group uselessly or even damagingly intrusive? Does not the idea of the group violate the fundamental spirit of individual enterprise?

Let us begin by asserting what a team *is not*. A team is not merely an aggregation of specialists who are in the same room at the same time or even engaged in the same activity. Clinical conferences and symposia of specialists for study, diagnosis and treatment bear only superficial resemblances to the entity that we are considering here. A team must have "the quality of organism." In fact, the value and significance of the team structure is to be sought in this unique dimension. It does not come about merely by the summative effect of more people, more ideas, more imagination, more energy—more of anything, for that matter.

Each individual contributes much or little to the life of the group for he brings to the aggregate the sum of his personal reaction patterns, his beliefs, prejudices, knowledges, maturities and sensitivities. His function and experience in the group process can be understood only when this fact is clearly comprehended. At the first level of development of the team, information is exchanged, individual interpretations offered, decisions made, and actions initiated. The most conspicuous quality of this early stage of development of the group is the high level of resistance and rigidity reflected by its members. There is an active competition for acceptance of ideas. The members of the team are, in this stage, mainly engaged in "telling the other fellow." Despite the fact that this process of communication of facts and ideas is basic and essential for group growth, there are some natural deterrents to its effective accomplishment.

The principal deterrent is one of language—a semantic one. The scientific jargon, the technical cant, and the professional argot, though familiar and even impressive to the user, may have little meaning to others in the group and may actually produce suspicion. When we do not understand language, we tend either to feel inadequate, or we become hostile and rejecting. Gradually as each member of the group tries to communicate with his fellows, there is a certain "leveling off" of specialisms. A good deal of natural transliteration and translation must occur before suspicion is dissolved. The semantic obstacles are reduced most effectively when language is used operationally and as an instrument for discovering common areas of understanding.

The struggle to retain individual identity is also strong. We all feel the loss of personal significance when our uniqueness is threatened. The new member of a group reflects the quality of possessiveness about his ideas and information, and though he may wish to give, he actually struggles to retain and to husband his fact-and-feeling resources.

Learning by Teamwork

In the later stages of development, the team learns how to take advantage of the many possibilities provided by its special structure. In the clinical group the patient is examined, studied, and treated as a multidimensional problem. Each member sees his own facts, ideas, and action in a supportive frame of the total patient.

But earlier than would otherwise be true, the team member also sees the urgent need for *new* facts and new relationships between these facts. He grasps the need for basic research to provide answers to questions framed more basically and more broadly. He requires answers to questions that are much more inclusive than he would and could ask alone.

It is obvious that the leadership which is so basic to team growth cannot be authoritarian. A well disciplined group is not necessarily a conforming one. It is the responsibility of the leader, however, to so manage the individual participation that the full value and effect of each can be gained and the benefit of mutual support, protection, and stimulation can be attained.

The most dramatic aspect of the team-in-function is the reduction of individual dominances. A team is not in any sense merely a group of consultants who are emotionally and intellectually subservient to a dominant specialist of the group. The recognition of complete and unquestioned professional equivalence —that no one specialist is "the big gun"—distinguishes a well developed team. Hence, a team becomes increasingly effective as it becomes less and less a hierarchy. Its best development is horizontal rather than vertical.

Cleft Palate Program

The study and treatment of children with cleft palate and cleft lip provide an excellent opportunity for the application of the principles of the team approach and a good illustration of its effectiveness and its problems. There has been for some time a common agreement that habilitation programs for these children could and should be improved. The general dissatisfaction with the clinical results derives mainly from the fact that this organic disturbance creates so wide a spectrum of problems requiring diversified but coordinated solutions.

The implications of this congenital deformity are multidimensional. The child's earliest biological functions are disturbed. He must eat and breathe differently from normal children. His acceptability to his parents may be profoundly affected by the attendant facial disfiguration. Since he cannot nurse at breast, the security of that close physical contact with his mother is denied him. The cleft palate child appears to be more vulnerable to certain diseases of the head spaces—ear disease with associated hearing loss, upper respiratory infections, and early and extensive breakdown of dental tissue.

The ability to speak is our most distinguishing human attribute. It follows then, that anything that affects speech and communication unfavorably affects the most human part of us. This structural aberrancy imposes the severest limits upon normal acquisition and development of speech in the child. His speech will, without aid, be characterized by a lack of intelligibility and possess very distracting voice qualities. Growth gradients in critical structures of his head may be altered. As he becomes aware of himself as a person, his self-evaluation may produce disturbances in his emotional and social adjustment. It is obvious that no single medical or paramedical specialty can alone prevent or reduce effectively the constellation of penalties produced by his deformity.

Through the cooperation and support of the Children's Bureau of the Department of Health, Education, and Welfare and the Professional Colleges of the University of Illinois and its Division of Services for Crippled Children, a Cleft Palate Center and Training Program was established in the Colleges of Medicine and Dentistry. Its purpose was to provide an organization in an educational climate which would prepare itself to help those persons who were, in one way or another, responsible for the care of cleft palate children in the American community. Its staff was gathered from the major academic and clinical departments of the professional schools of the University. The assignment of members to the teaching group crossed established division, department, and college lines. On the highest level it received its administrative direction from the office of the vice president in charge of the Professional Colleges of the University.

Each staff member is a regular member of the department of his specialization and serves part time in the Cleft Palate Center and its teaching and research program. That portion of the member's time which he gives to the Center and Training Program is paid for from funds provided for in a special budget. These funds, together with those for material, supplies, and equipment, are disbursed through the Division of Services for Crippled Children. In the State of Illinois, the Division of Services for Crippled Children is within the University structure rather than in a State department of public health or welfare.

The following departments and divisions of the Professional Colleges cooperate: Pediatrics, Anesthesiology, Surgery, Otolaryngology, Physical Medicine, Nursing, Orthodontia, Pedodontia, Prosthodontia, the Speech and Hearing Center, Psychology, Social Work, the Division of Services for Crippled Children, and the Research and Educational Hospitals.

Coordination of services and facilities is accomplished through a director and his administrative assistant, a technical assistant, and a clerical staff. The facilities are located in the buildings of the colleges of medicine and dentistry and the University Hospitals, and consist of offices, laboratories, clinic and conference rooms. The program also has a special laboratory for the study of growth and development of children. It depends upon the office and field services of the Division of Services for Crippled Children and its department of clinical photography for many of its essential services.

The Teaching Plan

Since its mandate was to teach, the staff of the Center and Training Program asked itself, "What is to be communicated?" A review of the literature of cleft palate revealed much that was highly controversial, confusing, and subjective. On the other hand, it also showed that some of the most resourceful, imaginative, inventive, and earnest effort applied to any human disability had been applied in the treatment of this disability. It was clear that increasing specialization and fragmentation had produced many useful knowledges and skills. At the same time, it had induced an unrelatedness and a gradual loss of the highly important concept that the deformities of cleft palate and cleft lip have significance only because they are disturbances *of a child*. It was determined, therefore, to *return* the facts and the practices to the integrating frame of the whole child.

By studying and treating the child, we proposed to teach ourselves and to teach others. It was apparent, too, that a continuing program of basic research in growth and development supportive to the processes of instruction was urgently necessary. We purposed to do what we had to do by corporate feeling, thought, and action.

About 95 percent of the patients referred to the Center are under the care of the Division of Services for Crippled Children. The rest are referred by private physicians, dentists, speech pathologists and therapists, social, health and welfare agencies, both voluntary and tax-supported. All patients are admitted to the Educational and Research Hospitals through the Pediatric Out-Patient Clinic. The pediatrician of the Cleft Palate Center also serves in a liaison capacity between the Division of Services for Crippled Children and the Educational and Research Hospitals. As a member of the Department of Pediatrics, he supervises and directs admission of patients and their disposition. All patients are provided with the fullest type of pediatric workup. Clinical, laboratory, and research departments of the University Hospitals provide the services to accomplish the workup.

Many infants are admitted during the early weeks of life. These children become a part of a longitudinal research study of growth and development of the head. Every 3 months during the first year of life, every 6 months during the second and third year, and once a year thereafter, these children move through the growth and development laboratory. By means of roentgenographic cephalography and laminagraphy and by oral impressions and casts, the growth of their heads is recorded and measured.

Through this research greatly improved understanding of the nature of cleft palate has been gained. It provides the surgeon, the dentist, and the speech pathologist with information which makes accurate diagnosis much more secure. It assures that more often the "right thing is done by the right person at the right time" in the program of care. Much that is being learned through this basic research has direct application to the problems of other types of handicapped children.

Continuous Contact

Frequent visits of the child to the Center provide opportunity for continuous contact of the parents with the medical social worker, and enable continuing pediatric surveillance by the full facilities of the medical and dental clinics. One of the most impressive outcomes of the extensive contact with parents is the revision of their attitudes toward the deformity, the reduction of their anxieties concerning the child's future, and improved understanding of and cooperation in the clinical processes. Since they are conceived of as members of the team and so dealt with, they become more objective and more able parents of their exceptional children.

Our research makes it very evident that children with cleft palates are distinguished more by their differences from each other than by their similarities. No two cleft palates are alike, and the mode and time of treatment are more likely to assure restitution if there is recognition and assessment of these variations. The final decision as to the kind and pattern of treatment rests with the team. Through repeated staffing, the time and character of intervention is determined.

If the child's lip is involved, it is usually surgically repaired as soon after birth as the pediatrician and surgeon feel that he is physically able to undergo the operation without danger. Surgery on the hard and soft palates may be deferred until the child's growth records indicate that an optimum condition prevails. The objective growth records provide a basis for the surgeon's decision as to the technical procedures likely to produce the best functional result. Our research reveals that some children have a better chance for a functional recovery of the use of their palates if surgically treated within the first year or two. It also makes apparent that in many others, surgery performed at too early an age will result in a functionally inadequate mechanism. Because the effects of surgery are not easily reversible, it may occasionally make secondary treatment by surgical procedures or treatment by nonsurgical means much more difficult.

Our clinical and research records provide evidence that many children profit by an interim use of prosthetic speech aids. In a considerable number of these children, surgery on the palate is not the procedure of choice and they can be habilitated much more safely by permanent prosthesis.

Such prosthetic speech aids are often designed, constructed and fitted as early as the third year or as soon as sufficient teeth have erupted to provide retention in the mouth. A gratifying effect of early interim, or permanent prosthetic care, is the rapid and easy adjustment these children make to their speech aids and the remarkable speech improvement that results during the critical period of speech acquisition.

During the early years of the child's care program, his response to surgical and/or prosthetic treatment is followed by the team. He is followed carefully by the pediatrician who deals with him as a usual child with special needs. The pediatrician and the otolaryngologist of the team make every effort to maintain the best possible upper respiratory and otological health. Ear disease is promptly treated either by the Center or the local ear-nose-and-throat specialist. The audiologist continues study of his hearing status.

Early Dental Care

Dental supervision and restorative care begin early. Even before the eruption of the deciduous teeth, the dental staff has been able, through the X-ray records, to determine the child's dental potential, the probable pattern of dental development, and to begin early management of his dental problems, which may be many. Dental hygiene instruction of the parents and child, restorative treatment of the first teeth, and orthodontic guidance or correction are instituted. It is important to observe that in cleft palate children, orthodontic treatment is more properly conceived of as orthopedic since the correction of the deformities of the jaws may involve bony structures of the head as much as the disarrangement of individual teeth. It is not unusual to provide oral-orthopedic treatment antecedent to palatal surgery or the fitting of prosthetic speech aids. Occasionally, oral-orthopedic guidance and even correction is accomplished by a single combined prosthetic device.

Early contact with the child and parent on the part of the speech pathologist gives opportunity to prepare them for the emergence of the speech problems characteristic of cleft palate children. Parental instruction, referral to competent and experienced speech therapists, or admission to summer speech training centers of the Division of Services for Crippled Children are arranged. Continuing records of speech development and improvement are maintained by frequent phonetic analyses and speech recordings. Through the field services of the Division, social casework and nursing care in the child's home area are provided. Close liaison is maintained by the staff medical social worker, the physicians, dentists, and speech pathologist with the field work. Educational guidance and school placement counsel are provided by the staff psychologist who uses the psychological services of the State and university agencies.

Children referred to us at a later age are not included in our basic growth and development series. However, a team diagnosis and treatment recommendations are available and these are based upon information gained through the use of the same diagnostic instrumentaria and processes used with children who are under long-term study.

The Training Program has many facets. Instruction of medical students in clerkships, interns, residents, and students in post-graduate courses in many departments of the colleges of medicine and dentistry proceeds through the year. Short courses of varying lengths are provided by the Program for specialists who come to the campus from many parts of the country. Admission is granted to those who seek instruction to participate in the organization and development of improved care programs for cleft palate children on the community level. These courses are designed to assure a fundamental understanding of the nature of cleft palate and cleft lip through contact with the results of basic research, the clinical management of cleft palate children, and an identification with a functioning service-team.

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[1] Backus, Ollie: Collaboration Among Psychiatrists, Pediatricians, Clinical Psychologists, and Speech Therapists. *The Nervous Child* 9, 3: 242–56, May 1952.

New Jersey's pioneering program builds parental skills and confidence through . . .

HOME TRAINING FOR THE MENTALLY RETARDED CHILD

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THE MOTHER of a retarded child, speaking of the need for parent counseling and home training, at a conference on retarded children, described the happy lot of parents who do not have these special problems. "Parents who are bringing up normal children," she said, "have so much help in knowing what to expect of their child and what to do for him. They have the other children in the neighborhood. They have their own nephews and nieces. And besides this, they have all the baby books with their charts and tables and good advice."

She went on to mention the toy manufacturers, who produce educational toys for specific age groups, and the record companies and book publishers, who know so much about the needs of normal children and have designed their products to meet these needs. And finally there are the schools, which most parents can look forward to, where trained teachers will help them in the education of their child.

Parents of normal children do receive a great deal of accurate information and good advice from a great many sources. They know in general what to expect of their child, physically and mentally, and they know how other people are handling the problems that arise in their own family. The parents of retarded children do not have such support. As a rule, they have to face their problems alone. Or, if help is offered, it is likely to come from well meaning people with little or no experience, whose advice only adds to the distress, confusion, and misunderstanding which confronts these parents on every side.

The term "mentally retarded" covers a wide range of disability, from the mildly to the very severely handicapped. It includes individuals who, under ordinary circumstances, can lead fairly independent lives, others who require social protection of some kind, and still others who will always be dependent on their relatives or the community for physical care.

Mildly handicapped children have the benefit of the public schools. In many places, there are special classes designed to meet the special needs of these children. State residential schools give custodial care and some training to the most severely handicapped. But there are a great many children who do not come within either of these groups. Some are so severely handicapped that they would be admitted to the residential school if there was space for them. Some are so capable that they would be admitted to the public schools if there were classes for them. In many places today, these are "forgotten" children, living at home, without the help which our modern techniques in medicine, psychology, and social work could bring to them.

The Home Training Program

New Jersey's Department of Institutions and Agencies maintains four institutions for the care and training of mentally deficient children. But these institutions have long waiting lists and many children, who should be receiving training of some kind, are forced to remain at home. In September 1943, the Department decided to set up an experimental program, to be called "Home Training," which would bring some of the services and techniques of the institutions to children living in their own homes. The first purpose of the program is to guide and counsel parents in understanding and training their retarded child so that he can take his rightful place in the home and community or, if this is impossible, so that institutionalization can be postponed with the minimum damage to the child. Early referrals to the program were from the waiting lists of the institutions. As the program became better known, children were referred by physicians, social workers, educators, and even parents themselves. Most of the children referred had, as a rule, I. Q.'s below 50.

A program of this kind, which aims at better community understanding of the problem of mental deficiency and better home and family adjustment, utilizes many kinds of professional skills and it is difficult to say which of these should be given first place. The New Jersey program was placed in the State Department of Public Instruction. A similar service, established in Massachusetts a few years earlier, had been placed under the Department of Mental Hygiene. The Massachusetts program was carried on by social workers, the New Jersey program by persons trained in education, psychology, and guidance. But both programs have had the same goal—to bring what knowledge we have about the mentally retarded into the homes where these children live.

FOR THE RETARDED, as well as the normal, "play," as the 1919 White House Conference on Children asserted, "for grown people is recreation, the renewal of life. For children, it is growth, the gaining of life." Here they learn to swim.

Effect on Parents

The first result of a home training program of this kind is that parents acquire a feeling of social support, of "belonging" to the community again. Too often, the parents of a retarded child are burdened by unnecessary doubts and fears. When these are intensified by the indifferent, or even hostile, attitude of the community, the members of the family feel compelled to withdraw from all social and neighborly contacts. According to reports from a New Zealand home training program, the greatest needs of the parents of retarded children are for recognition and moral support. This New Zealand program was carried on through correspondence. A teacher in Wellington found that even through letters she was able to give a woman living on an isolated island the strength she needed to work with her retarded child.

In New Jersey the home teacher frequently finds that she is the only contact the mother has outside her immediate family. Some of these families have lived in their communities for years without knowing that there are other families with retarded children living not far from them. The fact that there is someone besides themselves interested in their child goes a long way toward dispelling fears and tensions. The teacher's visit sometimes takes on almost the quality of a social event. Soon grandmothers and aunts drop in to hear what she has to say. And before long neighbors are asking about the child's progress.

The home teacher encounters little or no resistance on the part of parents to her offer of assistance and guidance. This may be due to the fact that no matter what the source of the referral, the teacher always contacts the parent before visiting the home, explains that she had been asked to visit the home, and requests confirmation from the parent. The fact that the home training program is not forced on the parent but in every case is requested by the parent, results in opening the door to the teacher and welcoming her aid.

One of the first things the teacher can do for a mother is to help her understand her child's limitations. Parents very often, in their anxiety to have their children learn, try to push them beyond their abilities. This can only lead to a feeling of futility and defeat. The parents who insist that their child could talk if he weren't so lazy are only deluding themselves. A true understanding of the situation relieves the pressures placed on the child and makes for happier living all around.

Many times parents, in attempting to compensate for a child's deficiency, buy toys which he cannot use and does not need. They may buy the most expensive doll carriage, only to discover that their little girl does not know how to play with it, because such play requires imagination. The teacher can be of great service to parents in helping them select toys that are suitable to the mental and physical development of the child and that have teaching as well as play value. Manipulative toys, such as the ring pyramid, bang peg, large peg and board, nest of blocks, and others, are as suitable for retarded children as they are for normal children, except that the retarded child may use them with better result at a later age.

The Teacher's Role

The teacher must also show parents how to teach. It is always difficult for a mother to assume a teacher's role, and sometimes it is impossible. The first time a child pulls a chair to the door and removes the latch it is very hard for the mother, who must think of some other means to keep the door locked, to see this as a real accomplishment. But she can learn from the teacher of many situations in the home which can be turned into learning experiences.

A mother can be taught the importance of pointing things out to her child and naming them, so that even if he can't name them himself he will be able to recognize them. Mothers sometimes do very little to encourage speech development in their child because they have been told that he will never speak. When a mother realizes that for her retarded child "speech" may mean making his wants known by gestures, single words, or phrases, she will do as much as possible to widen his experience and enrich his environment. She will make books for him with pictures of clearcut objects. Later she will buy colorful books and sit with him, telling him the story in simple words that he can understand. She will buy him appropriate records and he will learn to distinguish tunes and sounds. She will take him out to a few familiar places so that he will come to know some things outside the home.

Fathers, too, can be of great help, especially on these outings. One father takes his little boy out every evening, alternating between a visit to a pet shop and a visit to the park. Another takes his little girl on a regular round every Sunday morning. This includes picking up brother at church, going to the bakery, visiting grandmother, and stopping to see the ducks. The world is full of wonderful things to see and hear and know, and retarded children can learn to enjoy many of these things if they are introduced to them gradually.

A HOME-TRAINING teacher's main function is to help parents worry less and turn their thoughts from profitless anxieties to constructive planning. Never taking over the training herself, she shows mothers how to teach elementary habits.

Parents of retarded children, at some time or other, have to consider placing their child in an institution, or at least taking the necessary legal steps to make this possible. This is a very difficult and painful decision for a parent to make. But in the case of children who are so severely retarded that they require physical care, or so extremely distractible that their presence disrupts the home, institutional care is almost a necessity.

Although a home training program is established primarily to help parents train their child so that he can remain at home, the teacher must not close her eyes to the fact that some children's needs can not be met outside an institution. She must prepare the parents of such children for what is inevitable, so that when the day comes for the child to be admitted to a residential school, the parents will be ready for it.

There are a great many questions about institutional placement which, when answered to the parents' satisfaction, put their minds at ease and help them to arrive at a solution. Parents contemplating placement are always concerned about the care and treatment their child will receive. Much unnecessary worry can be avoided if they are able to talk over their problems with someone who understands them. If it is clear that the decision will have to be to send the child to an institution, the teacher must realize that this cannot be accepted immediately, that the parents need time to adjust themselves to the idea of parting from their child. The teacher can ease this process by helping them to see the need for such a solution. Sometimes a parent feels that his child is being placed in a residential school because the home training has been a failure. The teacher can assure the parents that this is not true and that everything that has been done for the child at home will help him to live a happier and fuller life at the school. A visit to the school or a talk with another parent who has a child there can do much to dispel the apprehension which a parent naturally feels regarding such placement. The institutions, on their part, encourage visitors, especially parents, for they are concerned with the happiness of the children put in their care.

Joan and Robert

Parents of retarded children have a great many other problems, which may be extremely complex and which cannot be resolved quickly. Some parents need only a few visits from the teacher to see how to go about handling their problem. In such cases the teacher will not be needed again unless circumstances change. But for the home training program to be effective a long time contact of some sort must be maintained with the parents. They must know that the teacher is available if they need her.

In home after home, the teacher finds parents facing the same problems. One case history differs from another only in its superficial aspects. In any one of them, the problems which have just been discussed abstractly can be seen in their concrete, human form.

Joan was a little girl of ten when the teacher first visited her home. Her mother, Mrs. K., was concerned about the lack of training facilities for the child and had been pressing for her admission to an institution. The teacher had been sent to the home in response to this appeal for help. Then, as now, there was a long waiting list and little chance of the child's being admitted to the institution and it was hoped that the teacher could help the parent train her child at home.

The teacher found Joan to be a pleasant child, of mongoloid type, with a mental age between three and four. She was the third in a family of four, well behaved, and secure in the love that surrounded her. The mother had done a remarkable job in training her in habits of self-help, so that she was quite self-sufficient.

After a few visits the teacher discovered that Joan was being taken out very rarely. Mrs. K. said that at one time she did take the little girl on excursions to town. But she had found it increasingly difficult to brave the stares and glances of curious people and had gradually stopped taking Joan anywhere. It was obvious that this experience had left its stamp of bitter resentment on Mrs. K. and had created antisocial attitudes toward her neighbors and society in general. Not all the people that Mrs. K. met were motivated by morbid curiosity. There were some, certainly, who were filled with sympathy and compassion because they, too, had a little Joan at home. But there was no way for Mrs. K. to know what was in the minds and hearts of her neighbors, because no one spoke of his problem and no one mentioned the words "mentally retarded."

The day the teacher announced that she was going to take Joan to the home of another little girl was a memorable one for Mrs. K. The family talked about little else for a week and when the day arrived everyone was out to see Joan go off with the teacher. Other visits followed, and these trips served a double purpose. Joan learned, among other things, the joy of having a friend of her own. And Mrs. K. herself soon got the strength and courage to take Joan out in the community, visiting friends or family, or merely shopping.

As time went on, the teacher was able to tell Mrs. K. many things which relieved her anxieties and gradually gave her a new outlook on life. She learned that Joan was not the only child in the community who was retarded, that there were many others who were living at home and receiving no instruction from any source. She learned that Joan could profit from home training and that the success of the program depended principally on Joan's mother, on how much time she was willing to devote to it. She learned that the needs and feelings and emotions of retarded children are very like those of other children. Eventually Mrs. K. realized that she was the key person in the situation, that she carried the major responsibility, and that her attitude toward the child could affect not only the attitude of the whole family, but that of neighbors and friends as well.

At first the teacher made weekly visits to this home. Joan learned to cut, color, sew, and do other craft work. No academic work was undertaken. Instead, emphasis was put on the types of activity which would help her fill her days. Joan made and sold pot holders, enjoyed making scrap books, learned a simple embroidery stitch, and made a great many mats. All very simple things—but accomplishments which were the result of many hours of patient guidance on the part of both mother and teacher.

Inevitably, the time came when the family no longer needed such service. The teacher, aware that this time would come, began preparing the mother for it in advance. She did this by gradually lengthening the time between visits. They decreased from weekly to monthly, and finally became yearly.

Joan is now twenty and at home. Her days are filled with the kind of activities that are satisfying to her. She makes little demand on the family and at the same time makes her own contribution by sharing in household chores. Although the teacher no longer visits the home, the mother and family know that the service of a home teacher is always available if circumstances should make this necessary.

Such circumstances sometimes arise. Robert was 5 years old when the teacher first visited his home. He was well developed physically, but slow in speech development and self-help habits. The mother's chief concern at this time was to develop these habits. The teacher made weekly visits to the home for 2 years and then succeeded in placing the child in a day class.

For the 2 succeeding years the teacher had little or no contact with this family. Then the father died suddenly. The mother, knowing that the teacher had always been there, ready to help her, did not hesitate to call on her. In this particular case, the best plan was to place the child so that the mother could work to support her two other children, and this was done.

COMPANIONSHIP of other children is as important to the retarded, as to the normal child. The home-training teacher is in a position to bring these children together. This, in time, can lead to friendships among parents as well as among children.

Working Outside the Home

A home teacher's work inevitably extends beyond the home. The retarded child needs the companionship of other children and the teacher is in a position to bring these children together. This leads in time to friendships among the parents and to the growth of classes and centers for both the children and the parents.

In New Jersey, the teacher is active in organizing play groups for young mentally deficient children which are staffed with volunteers. There are now three such groups in the North Jersey area and another is being planned. The children attending are usually on the list of the home teacher, and are either preschool or too severely retarded to attend special classes. The home teacher is present at all sessions of the groups and guides the work of the volunteers. In this way she can follow the progress of 10 or 12 children at the same time and so make her services more widely available. She acts as a liaison between the group and the home and so is always in touch with the parents.

Perhaps one of the greatest forces in the whole area of mental deficiency has been the phenomenal growth of parent groups for retarded children. The teacher must take an active part in the work of such groups. She must always be ready to share her knowledge with anyone interested in helping retarded children and to do what she can to promote sound principles and philosophies.

New Jersey's association of parents began in 1947 when 43 parents who were being seen by the home teacher met together to discuss their problems. Today there are 14 units of this kind in New Jersey and 375 throughout the United States, with more in the process of being organized. A bond of understanding and fellowship permeates these meetings. Parents, dedicated to helping their children, visualize and plan projects which sometimes take years to realize. These have included summer camps, sheltered workshops, discussion groups, nursery groups, and new legislation to open public schools to their children. One of the first classes for severely retarded children was established in Ridgewood, N. J., in September 1948. It has been in continuous session for 7 years and has contributed to the well-being of 60 children. Projects of this kind become realities because parents are willing to make the necessary sacrifices and because other civic-minded people are also ready to give of their time and their money.

This school had to turn to the community for help. The parents could not meet the total cost but the community responded generously. The YMCA and YWCA opened their swimming facilities to the retarded children and provided individual instructors. The Nursing Service supervised the health program. A church provided the housing. And a civic organization donated funds.

Much the same thing has happened in California, Connecticut, New York, and other places. The little town of Point Pleasant, N. J., boasts 100 percent participation of all civic organizations in its "Little Carpenter School." This town is determined to provide training for every retarded child. Fresno, Calif., is planning an even more ambitious project called Kalso Village. This will be a center which will include every kind of facility needed in the care, training, and education of retarded children.

The Ideal Program

These activities which have already been undertaken for retarded children are modest in scope, but they show that a total program is possible. The total program, which we hope some day to see in operation everywhere, will have four distinct parts or aspects.

First of all, there will be a home service for mothers of very young children or of children who are not eligible for centers or special school classes. Here a teacher will bring the parents the information they need in order to care for their child properly. She will guide them in training the child, in choosing toys and in selecting appropriate activities for him. She will help the parents to develop the child's abilities to the fullest. She will inform them of all the resources available in the community and the State so that they can plan the child's future intelligently. And she will also give the parents the strength and support that they need so much when they first realize that their child is not normal.

In the second place, a complete program will maintain community play centers. The present play groups in New Jersey and elsewhere have proven their worth. These should be made available to preschool children and to all others who, for any reason, are unable to attend public schools.

Thirdly, the program will maintain special classes under the auspices of a public agency. In New Jersey, the recent passage of the Beadleston bills made it possible for severely retarded children with I. Q.'s below 50 to be admitted to the public schools. California, Wisconsin, Minnesota, Connecticut, and Ohio have passed similar laws. In Ohio 115 classes for severely retarded children were established within a 3-year period after the passing of such a law in that State. This is progress of which Ohio can be justly proud.

And, fourthly, the program will, of course, maintain a residential school. It is to be hoped that, as other phases of the program are developed, the number of cases needing residential care will be reduced and the long waiting list eliminated.

So much is being done for retarded children that was undreamed of only a few years ago. Many places now have classes in public, day, and residential schools, summer camps, sheltered workshops, and social and recreational groups. This has come about because of an awakening on the part of the community to its obligation toward these children, because of the formation of parent groups, and because of the willingness on the part of professional people in all branches of social service to cooperate in achieving these ends. So many voices are now joining with the parents', asking that the future be made brighter for these less fortunate ones—for they are also children.

Reexamination of agency-client relationships and agency responsibilities lead to . . .

CHANGED APPROACHES TO THE UNREACHED

RALPH W. WHELAN, M. S. W.

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INTEGRATED, community-wide programs for delinquency prevention are relatively new devices in community organization. While the generic nature of the services they attempt to supply may remain essentially unchanged, certain important modifications in technique inevitably take place. Therefore, in examining over-all community patterns, it is important to consider what departures or changes in practice have accompanied them. Without an understanding of these changed elements of practice—whether they be new, adapted, or a return to former methods—the full impact of the overall plan can be lost, for shifts in community planning almost inevitably call for changing emphases in the area of practice. In the 8 years since the establishment of the New York City Youth Board in 1947 many such changes have come about.

The Youth Board was established for the purpose of delinquency prevention and control in the high delinquency areas of New York City. Its program has rested on the premise that coordination and expansion of existing social agency resources, with the aid of funds supplied by the city and reimbursed 50 percent by the State under authorization of the State Youth Commission Act, would have the effect of bringing needed services to those not receiving them, and would thereby reduce and prevent delinquency in the community.

Accordingly, a network of services for youth was established in those arease of the city that were found to require them the most. Almost all the established resources of the community, public and voluntary, were thus drawn into the program, either by expansion of already existing services through Youth Board-agency contract or by direct purchase by the Board of services for specific families and children.

In addition, the Youth Board established several of its own directly operated projects, either for purposes of demonstration, or to satisfy critical needs in certain areas. The services under the overall plan include family service, child guidance, group psychotherapy, youth counseling, social group work, recreation and "detached" operations with unaffiliated streets clubs, or gangs.

Implied in all this is the necessity for coordination. Obviously, the agencies and projects could not be expected to supplement each other effectively without some central planning and control.

Types of Clients

However, what was not obvious to many participating agencies was the necessity for determining the focus of the program with respect to the *types* of clients to be served. It was well enough to say to an agency: "Here is so much money; it is to be spent for family service (or group work, or whatever)." It was another thing to tell an agency: "Here is money; we would like you to spend it mainly for services to certain *types* of cases that you previously did not serve."

A principal reason for confusion and difference of opinion lay in the very extent of the need. Too many professional and lay persons concerned about delinquency and children's problems in general tend to proceed on the assumption that as long as the funds are spent on services that children need badly, the problem is being adequately attacked. Actually, such an approach would not penetrate deeply enough.

What types of cases was the Youth Board eager to have served? The clue can be found in the conclusion reached by Bradley Buell of Community

Research Associates, Inc., in his St. Paul study[1]—that a small percentage of families and individuals with chronic, knotty problems, when they are served at all, are the recipients of a large percentage of community services, and that the services they receive are administered in an uncoordinated, diffuse manner that has no real effect on the *totality* of their problems. In other words, while many of these families are known to agencies, they are not actually "reached." The Youth Board chose to call this group "the unreached." They are those who have not continued in treatment or whom the agencies considered inaccessible to treatment.

Who are they?

In the field of services to individuals and families, the "unreached" are those families that live under substandard conditions, subsist on a marginal economic level, are often chronically dependent on public welfare services, and show little change in their general "problem" pattern from one year to the next. Not only do they pose a *present* problem to the community and to themselves; by the very nature of things, they also tend to perpetuate themselves, so that their offspring become dependents, delinquents, and the inmates of public institutions.

For agencies that attempt to help them with their personal and family problems, they present apparently insuperable difficulties. They do not keep appointments; they are inarticulate; they do not "relate"; they appear to have no anxiety or insight that might impel them toward a treatment relationship, either on an environmental or a deeper level. Or, if they do, their entire impulse seems to be in the direction of dependency. They are, in short, either actively or passively resistant.

Agencies that work with groups are also aware of the "unreached." They usually do not identify with or use the agency services, but a few become known to the settlement, "Y," or playground worker because of the destructive or negative behavior of their children. Some are affiliated with neighborhood gangs who are involved in antisocial acts in the community while others are a disturbing influence because they cannot participate with established groups in the agency. They are those who contribute consistently and stubbornly to the delinquency and crime statistics. Punishment has not been an effective deterrent and efforts to treat and rehabilitate have been inadequately conceived and ineffectual.

The Youth Board attempted to focus its relatively limited resources on this group. And, because special measures were needed to reach them, certain adaptations had to be made insofar as the daily practice of casework, group work, and related disciplines were concerned.

The Youth Board contracts with voluntary and public agencies enabled the agencies to employ and train staff to work with some of these families. In some instances, where established agencies could not offer the kind of treatment services required, the Youth Board established a special project.

The Referral Unit

For example, in the original Youth Board design, for each of the high delinquency areas, a referral unit was provided, about which the other services were to revolve. These units are still in existence, but the realities of reaching the unreached, and the pressures exerted by the unreached themselves, made certain casework changes imperative.

Originally, the referral units were conceived of as centers of delinquency detection stationed in the schools and working with various elements in the community. In these units a gross diagnosis of the child's problem was made, a decision about the appropriate treatment resource was arrived at, the client was prepared for the referral, and the referral was completed. In other words, the units were to serve as a "vestibule" into treatment.

However, by 1950, referral unit statistics and a study of cases in the treatment agencies indicated that there was a substantial group of clients who had to be considered more than ordinarily resistant to this process. Only one-third of the families known to the referral units could be transferred to treatment agencies. Of the group accepted by these agencies, approximately one-third failed to initiate agency contact or dropped out after one or two interviews. Accordingly the referral unit techniques were modified to meet the situation.

For one thing, it was recognized that the referral unit's contacts with the resistive client had to be of longer duration if proper preparation for referral was to be accomplished. This meant that the turnover was slower than anticipated, and that the referral unit caseworkers had to enter into treatment relationships more than would be necessary if the referral were rapid.

It also meant that in some cases referrals could not be made at all. The referral units, whenever possible, continued to work with these families to help them resolve some of their problems. Transfer to a different agency and worker was too threatening.

Because of the fears, anxieties, and resistances of these families, the referral unit staff had to develop a flexible approach. Many interviews were scheduled in the schools and homes. Early morning and night appointments were arranged at the convenience of the client. Broken appointments were followed up promptly and many school and collateral contracts were held to interpret the parents' and child's problems. When agencies other than treatment agencies had a prior contact or current interest, case conferences were set up to share information, coordinate planning, and interpret problems.

This account of the adapted functioning of the referral units is not intended to imply that their *basic* function was changed. Essentially, they remain what they started out to be—detection centers for the discovery, diagnosis, and referral for treatment of potentially delinquent children wherever possible in early stages of their maladjustment.[2]

Changes in Agency Concepts

In addition to the seriously resistive families, however, there were a good many referred families in which resistance was encountered from the agency with which the referral unit had made arrangements for treatment. While a good many of these cases actually arrived at their agency destinations, they did not remain long in treatment, if indeed this could be said to have started in the usual sense. A study of the agency approaches, duration of their contracts, and the actual responses of the clients, showed that the agency methods were not suited to serve the present needs of these clients nor to penetrate their facades to the point of getting them to utilize the agency's services.

What were most of the agencies failing to do? Although the Youth Board philosophy of reaching out was accepted in theory, there was considerable difficulty and delay in implementing it. Caseworkers were accustomed to working with clients who could ask for help voluntarily. Working with clients who do not recognize their basic problems required different skills and a more sympathetic and supportive approach. This meant that in the early stages of the relationship, workers had to learn to give more of themselves and to expect less giving from the client. Responsibility for keeping appointments could not be left entirely with the client. Reminders and followup were essential. Reality problems and family responsibilities would interfere or be used as excuses for a broken appointment. These factors had to be recognized. The client could only learn from experience that "talking it out" was not a waste of time. Workers who were able to make a real investment of themselves in their clients were able to involve them in a continuing treatment relationship. These workers learned to expect less from their clients, to accept more limited treatment goals, and to recognize the environmental problems affecting the clients' functioning.

Few workers were able to change quickly enough and many of their clients dropped out after a few contacts. Agencies questioned whether staff time could be used to involve this group of clients in treatment when other clients were on waiting lists and ready for help. The Youth Board was convinced that these families had to be helped.

What was needed was a more *outgoing* approach on the part of the agencies; more flexibility about appointment-keeping and related matters; more supportive treatment until such time as deeper, less obvious problems could be uncovered; and a pace of treatment *related to their ability to respond.*

The Youth Board tried a number of approaches to obtain some measure of change in practice. It worked with the voluntary contract agencies on several levels through conferences, advisory committee meetings, and professional seminars, as well as through day-to-day contact with referral unit workers. In these ways, the Board pointed up its concern for an unserved group that could not be helped through existing agency programs, and suggested that the community was supporting the agencies in the belief that their services were available to persons with a variety of problems. Actually, the agencies did not consciously or actively discriminate against the less-well-integrated families and children, but their selective and established functions served to exclude them, when readiness to accept treatment was used as a criterion.

The existing public interest and concern about the delinquency problem helped to move the voluntary agencies toward more outgoing attitudes and procedures. It gave them justification for changing their procedures and casework concepts so as to serve those they previously would not or could not help.

Some of the changes were these: Instead of placing clients on a waiting list, appointments were offered within 1 week of their transfer to the treatment agency. The referral unit summary was accepted by the agency as its intake, and the case was usually assigned to a worker who would carry it on a continuing basis. The agency worker maintained close contact with the referral unit worker and both workers encouraged the client to continue in treatment. If necessary, the referral unit worker participated in arrangements to help the client keep the early appointments. Agencies made more home visits and a special rate was paid to reimburse the agency for the increased expenditure of time. Every possible consideration was given to the clients' reality problems. The clients were not expected to move into discussion of emotional problems in the initial interviews.

Agency Teamwork

A major factor in helping agencies to achieve these changes was the concept of public-voluntary agency team relationships. Under some prevailing attitudes and policies, there was a sharp dichotomy between the responsibilities and functions of these agencies; the Youth Board program was founded on the concept of joint participation for the welfare of the same people, but with functions stemming from different auspices and origins.

Contacts with treatment agencies involved a good deal of give-and-take. Not only did the Youth Board staff contribute to their thinking, but the agencies' responses added to the Youth Board's understanding of its own problems, and enabled it to function with better comprehension of the agencies' problems. One concrete result was the modification of some contract requirements so as to make possible the kind of reaching-out in which both Youth Board and the agencies eventually began to cooperate.

Reimbursement for service to clients was established on an interview basis instead of the annual per-capita rate previously used. The rate of payment for a home visit was higher than for an office visit. Psychiatric interviews, psychiatric consultations, psychological testing, and remedial reading sessions were reimbursable at fixed rates more comparable to actual costs. An induction fee was established in recognition of the initial cost of involving a client when broken appointments run high.

Realistically, some types of problems could not be approached entirely through voluntary agency services, for that would have seriously curtailed services to other client groups and placed too heavy a strain on agency resources. While a good many adaptations in their services were actually achieved through the processes and along the lines indicated, some problems were too serious or relatively untouched to make it practicable to ask these agencies to tackle them. Consequently, the Youth Board had to undertake direct or cooperative operation of special projects, using special techniques.

One such project is Service to Families and Children, operated in conjunction with the New York City Department of Welfare. This project works with the most difficult families in the "resistive" group—those who cannot be referred to voluntary agencies because of the clients' complete inability to use services. These are usually disorganized families who have experienced serious deprivations on all levels. Emotionally they are unable to accept a therapeutic approach to their problems. They have to be convinced that they have problems, that something can be done about them and that the community cares enough about them to want to do something to help change conditions.

Aggressive Casework

Casework techniques of this project's workers are "aggressive" or "assertive," in that the worker reaches out actively to the family, works with it on any constructive basis, even though this may be somewhat distant from the eventual problem that must be tackled, and attempts to achieve any kind of recognition of a problem and a willingness to work on it that will impel the family toward social and emotional rehabilitation.

The "aggressiveness" of the project's workers is not based in hostility, threatening attitudes, or punitiveness, but is an expression of community concern.

The workers accept the clients' inability to ask for help and their unreadiness to work on problems. Home visits are made initially and sometimes throughout the period of contact. This is in recognition of the clients' heavy responsibilities and a specific indication that worker, agency, and community are sufficiently concerned to exert themselves in behalf of the parents and children. Direct recognition is given to the clients' previous unsatisfactory agency experiences, and they are helped to express their hostilities, frustration, anger, and bitterness about these past experiences. In some instances many scheduled and unscheduled home visits have to be made before the client is physically accessible. Because this is a slow process the agency keeps the worker's caseload down to an average of 20 families.

Gradually the client becomes able to listen and accept the worker's expression of concern and offer of help. This may be related to a health, housing, public assistance, or school problem. When the client sees that something does happen he can begin to confide in the worker and express concern about a marital or parent-child problem and sometimes a problem affecting his personal adjustment. When this stage is reached, the worker is free to proceed as he would in any agency. Worker activity in behalf of the client is more intense until the client develops the ability to act in his own behalf. A parent's visit to the school to discuss his child's problem, a trip to a medical clinic, and application for camp or housing, may be the first real step and positive contact this family has had with an outside agency in many years. Quite often the worker has to accompany the client when he takes the first step. Sometimes the worker continues to do this until the client is convinced that not only his "friend" (worker) cares, but the people on the outside are ready to help. Then the client is free to look at his own behavior and adjustment in relation to the outside world's standards.

The Youth Board has not actually introduced "new" techniques. Rather has it reemphasized the basic and durable qualities in social work that stem from community concern and in doing so has striven to reinforce the role of the parent, rather than to usurp it or to abandon efforts to help.

Group Work and Recreation

In the fields of group work and recreation, adaptations in practice also have had to be made to bring effective service to the individuals and groups currently unreached by such agencies.

The Youth Board's department of group work and recreation, responsible for supervising and administering the agency's contracts for services with public and voluntary agencies, developed a set of criteria for practice. These include a statement of standards, requirements and salary scales for the employment of supervisors and professionally trained and partially trained workers with previous experience. The size of the group load per worker and the number of individuals per group, selection of members, leadership training, quality of programs, and services are defined. Allowances are made to cover the cost of employing qualified workers and supervisors, and for supplies, equipment, and program specialists.

Modified from time to time in accordance with practical demands, these criteria constitute a central set of standards to guide the cooperating agencies. Since they define the services expected under the contracts, they act as a powerful lever for change.

To reach teenagers who do not ordinarily relate in a positive way to group work programs, the Board advocates more agency contacts out in the community. Program changes have been suggested and adopted, within limits of agency resources, to increase activities of special interest to this group. Examples are: more lounge facilities, fewer highly organized groups and more "drop-in" areas, where teen-agers can come and go without feeling an obligation to "join up" in a regimented way, or gain the impression that they are being "directed."

The Board also emphasizes the need for more qualified personnel with the kind of understanding and personality suited to work with teenagers. This involves the use of workers who are warm, sympathetic, and accepting, able to identify with the problems of teenagers, yet able to direct and guide them in the group. Through contract modifications and in other ways, it has encouraged agencies to work with small, loosely knit cliques rather than with large, highly organized groups.

It has helped agencies with recreation programs to add group workers to their recreation staffs, so that "problem" groups could reap the benefits of individualized attention. In general, it has stressed working outside the walls of the agency rather than waiting for unreached teenagers to feel a need to use it.

The most advanced expression of this "outside-the-walls" approach to the unaffiliated teenager is, of

SEEKING OUT, on their own grounds, youngsters with hostility toward peers, family, and community, and convincing them that he is their friend and can be trusted, this Youth Board worker's objective is to redirect the gang's interests.

course, the Youth Board's Council of Social and Athletic Clubs, which works with antisocial street clubs that have histories of lethal fighting and other destructive activity.

The "facilities" in which this project operates are the street corner, the hangout, the poolroom, and any other place where such groups are to be found. Many of the workers are professionally trained group workers specially chosen for their ability to relate to difficult youngsters and to understand their attitudes. They make friends with the gangs and their leaders, wherever they find them. They help them in any positive way they can, hoping to exert a constructive influence over them. Eventually, these youngsters are helped to substitute acceptable activities for their former ways of gang-fighting, loafing and general annoyance.

Some of the positive activities that have come out of these efforts are well-run dances, democratically organized, self-governing clubs, supervised lounges, out-of-town bus trips and camping. This project is not considered to be an end-solution to the gang problem. It does, however, give these youngsters opportunities they have previously lacked to build a bridge back into the community, and to establish habits and replace their antisocial patterns.

What Lies Ahead

Behind the pre-delinquent and delinquent children are a medley of deep-seated social and cultural problems that in some ways must be tackled even more fundamentally than through our present constellation of social services. Nevertheless, the underlying concepts and methods of the Youth Board program can, we believe, make a real impression on the problems, provided they are augmented by adoption of these concepts by the other community services.

While the Youth Board is convinced that it has already made qualitative contributions to the delinquency problem, the absence of sufficiently refined research techniques make it impossible to determine in most instances approximately what the specific and traceable effects of these approaches may be in measurable terms, especially in the light of the broad social and political forces that affect and complicate the behavior of our youth in the community. From the relatively limited standpoint of the Youth Board and related programs, however, we see certain facilities and approaches that must be created, reinforced or modified if full benefits are to be reaped.

In the total field of family service and other services to individuals—not simply in agencies affiliated with "problem-linked" programs such as the Youth Board's—it is necessary to revise concepts of agency-client relationships and agency responsibility to the community in order to approach more closely to the "unreached" and indeed, to help prevent other families from joining their ranks.

In the field of group work and recreation, similar broad adaptations are required. Increased and qualitatively different facilities, geared specifically to the needs of the unreached teenagers, are needed. These should be creatively conceived, based on certain general considerations that have to do with the special attitudes and behavior of this group. Facilities for the teenager should be informal and readily available at such times as they are needed, rather than at the agency's convenience, or that of other age groups with different needs. Adult leaders must be carefully picked for their ability to relate well to these groups; for their intuitive understanding of their behavior and needs; and for their flexibility and creativity in a variety of situations.

A good deal of practice-centered research is needed, to determine the effectiveness of specific techniques and the impact of overall programs.

With respect to the community as a whole, aside from obvious measures of community improvement that will foster sound family life, there is, in the relationship existing between the teen-age population and the adult community, a sensitive and critical area in which there is a crying need for positive action. The teen-age population, its special manners, behavior and customs, are often grossly misunderstood by the adult, to a point where hostility and tension are generated, and the teen-ager becomes a member of what often amounts to an "out-group." Active and consciously planned programs of public education are needed to improve adult understanding of teen-age psychology.

The constructive interests of the unreached family and the unreached teenager are identical with those of the general community. By focusing on this positive principle, rather than on "problem" aspects, and by meeting needs realistically, our community services, attitudes and general atmosphere can be improved to the point where, hopefully, there will no longer be any such group as "the unreached."

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[1] Buell, Bradley and associates: Community Planning for Human Services. New York: Columbia University Press. 1952.

[2] New York City Youth Board: How They Were Reached; a study of 310 children and their families known to referral units. Monograph No. 2. New York: Youth Board (500 Park Avenue, N. Y. 22). 1954. 115 pp. $1.

BIRTH AND GROWTH OF A HEALTH GUIDE

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MUCH HAS BEEN SAID about the changing character of medicine due to extraordinary technical advances in the last 25 years. During this same time other, more subtle, changes have taken place in the practice of medicine and in some of our social institutions contributing to the public health. The scope of the physician's responsibility has widened and the focus of his interest has expanded from the patient's pathology to include the patient's well-being.

This shift in emphasis is vividly illustrated, not only by the recent publication, "Health Supervision of Young Children,"[1] but by the process or stages through which it evolved. Its history is documentary evidence of how the physician dealing with children has widened his areas of interest, responsibility, and competence to include the emotional and social life of the child.

In the first quarter of the century there developed in many of the large cities of this country a service to mothers and babies, known as the Well Baby Clinic, or Child Health Conference. Initiated to combat the appalling infant mortality of the period, especially deaths due to diarrheal diseases, its original function was to serve as a milk station. Gradually the service broadened to include education of the mother in basic facts about infant care and about sanitation. Physician and nurse, working as a team, examined and immunized the child and instructed the mother in his care. Then, as infant mortality dropped and parents' concern shifted from the survival of the child to the problems of his growth and development, the character of the doctor-patient relationship changed also. Prevention, formerly focused on death and disease, now became involved in the area of emotional deviations and mental illness. These changes in what the parent wants from the doctor and in what he is prepared to offer have not been confined to any one group in the population. They have appeared both in private practice and in clinic services. Health supervision in the second quarter of this century came to mean a relationship between doctor and mother through which she receives guidance and support in being a good mother.

As communities took part in the child health conference movement they needed and sought advice on the *what* and the *how* of such a service. To meet this need the Children's Bureau developed, some years ago, a set of standards, called "The Child Health Conference—Suggestions for Organization and Procedure,"[2] which went through many editions and had wide use. But as times changed and new emphases became apparent, a new document was needed to replace this. Tailormade for such a project was the Child Health Committee of the American Public Health Association, and in 1949 this committee took on the job of producing a new manual. There was wide coverage of professions on the committee—pediatrics, psychiatry, dentistry, nursing, medical social work, nutrition, statistics—and each specialist contributed his part. But where was the mother who had come with her baby for help in the everyday job of living and learning? Where was the new focus on child care from a psychological as well as a physical approach? The committee itself went through a process of growth and reorientation which was sometimes painful, always time-consuming, but ultimately productive.

First drafts of the manuscript revealed that committee thinking was still running along the traditional lines of housekeeping and administration. Equipment, space, procedures, duties of staff members, records, are typical of the subjects covered. But in reviewing this material the subcommittee working on the project became more and more dissatisfied with it. The material was accurate and no doubt would be useful, but the heart, the essence of good health supervision, was missing.

A number of new approaches were tried, the successful one being rewriting by an expert in mental health education who was also a gifted writer: Dr. Nina Ridenour, Educational Consultant to Human Relations Aids. Working with the committee, Dr. Ridenour added valuable material, shifted areas of emphasis and developed the document as a whole rather than a collection of pieces.

Written with color and charm, the book is readable as well as substantial. Facts and figures are still there, but where usefulness is largely for reference purposes, they have been incorporated into the appendix. This appendix is a gold mine of specific information, extremely useful to public health personnel concerned with organization and procedure.

The body of the text, freed of minutiae, carries the story in a way to interest not only public health personnel but the other half of the audience, the general practitioners.

A Broad Focus

Somewhere along the way, the committee realized that its original focus on the child health conference was too narrow to influence broadly child health supervision. Private practitioners give most of the well child care in our country. And the principles of good child health supervision are the same wherever the practice takes place. So the committee refocussed on its audience and enlarged its manual to cover health supervision of young children anywhere in the United States.

Part I, Health Supervision, departing from the usual didactic approach of a description of the physical examination, moves directly into parent counseling. Questions about feelings and wishes are brought into the open. "How do women feel about being mothers?" "What do mothers want from a doctor?" Short case reports, conversations between doctor and mother, interview techniques in the form of possible questions, make the text interesting and provocative. A wealth of knowledge about mothers, their typical worries, and their feelings about themselves and their children is conveyed to the reader in simple attractive style, devoid of technical language. On the assumption that the physician is a reasonably good doctor and knows the technique of the physical examination, space is not given to repeating what he learned in medical school or what can be found in any good medical text. Instead, the "extras" of the physical examination are stressed. Many small but important details are given on how to make the experience of the physical examination as pleasant as possible for the child and his mother.

Recognizing that health supervision serves as one screening device for identifying children with physical and emotional handicaps, some tips are given on the identification of such children and their referral for specialized services.

Part II, dealing with the child health conference as a setting for health supervision, will be useful to doctors, nurses, nutritionists, and all health personnel working in such services. There follows a full appendix with techniques, procedures, record forms, and plans. There is a well-selected bibliography.

Professional workers outside the health field will also find this book useful. Through all the "social" professions there is a common core of knowledge. Much of the content of this book, though written for health personnel, has application to other fields which deal with parents and children. Social workers and teachers will find the material on parent counseling and on every-day problems in normal development as helpful to them as it will be to the many varieties of health workers. Although medically oriented, its contents are widely applicable. They are clearly written and remarkably free from jargon.

The product of a very able group of consultants from many fields, the book carries the general endorsement of the American Academy of Pediatrics, the Association of State Maternal and Child Health and Crippled Children's Directors, the National League for Nursing, Inc., and the Children's Bureau.

Few books produced by a committee rise above the handicaps of their origin. By the time everyone has changed everyone else's sentences and the text has been emasculated to permit every organization's endorsement, there remains a dull, colorless document. Here is an exception. Due to the personal efforts of a very able chairman, Dr. Samuel Wishik of the University of Pittsburgh, who is particularly patient in resolving differences of opinion, and to the skill of Dr. Ridenour in phrasing the compromises, the flavor of original writing has been achieved.

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[1] Health Supervision of Young Children; a guide for practicing physicians and child health conference personnel. Committee on Child Health, American Public Health Association, 1790 Broadway, New York 19, N. Y. 1955. 180 pp. $2.

[2] Children's Bureau Pub. 261. Government Printing Office, Washington, D. C., 1941. 41 pp. (Out of print.)

BOOK NOTES

TWENTY YEARS OF NURSE-MIDWIFERY, 1933–1953. Maternity Center Association, 48 East 92d Street, New York 28, N. Y. 1955. 124 pp. $2.

In 1932 this Association added an English nurse-midwife to its staff and opened a school to teach graduate nurses to be nurse-midwives, under the guidance of a competent obstetrician. Since then the school has certified more than 200 nurse-midwives who now work in virtually all the States and Territories, in 30 foreign countries, and on the Association staff. The successful work of the latter is shown in such figures as these: Of the 4,988 women delivered at home by the clinic staff in the 20 years reported on (98.8 percent by nurse-midwives and 1.2 percent by physicians), 5 died; 2 of these deaths were attributable to causes other than obstetrical. Fetal death rate was 3.9 per 100 live births; the neonatal, 1.5. All these rates were considerably lower, the report notes, than corresponding rates in the area surrounding the clinic.

A DEVELOPMENTAL STUDY OF THE BEHAVIOR PROBLEMS OF NORMAL CHILDREN BETWEEN 21 MONTHS AND 14 YEARS. Jean W. Macfarlane, Lucile Allen, and Marjorie P. Honzik. University of California Press, Berkeley and Los Angeles, 1954. 222 pp. $2.25.

Finding much literature on the incidence of various behavior problems that children present to child-guidance clinics, these authors have turned their attention to the same problems in "run-of-the-mill" children, chosen at random from a birth registry.

Mothers of about 100 children furnished information on certain kinds of behavior in their children at the end of 1¾, 5, 10, and 14 years of age. Forty-six problems are reported on. These are classified as problems associated with biological functioning and control, such as enuresis and food finickiness; with social standards, such as lying and truancy; with motor mechanisms, such as tics and nailbiting; with personality patterns, such as quarrelsomeness and temper tantrums.

Among the problems that declined early and rapidly were those concerned with elimination. Speech problems, fears, and thumbsucking began to decline somewhat later. Only one problem increased systematically with age, namely, nailbiting, which, says the report, "had begun to subside at the end of pubescence in girls and unquestionably would have declined for boys had our data extended beyond 14 years." Among the problems that reached a peak and subsided were insufficient appetite, associated with the high incidence of communicable disease. Some problems showed two peaks of frequency, such as at the preschool level and at late pubescence; among these were restless sleep and physical timidity.

RE-EDUCATING THE DELINQUENT THROUGH GROUP AND COMMUNITY PARTICIPATION. S. R. Slavson. Harper & Bros., New York. 1954. 251 pp. $4.

How a school for delinquents gradually changed from a punitive to a rehabilitative institution is told in this book by the man who started the change. The story begins in 1935 with a riot. At that time few therapeutic services were available. One of the most important elements in the transformation, the author suggests, is the cooperative efforts of all the adults involved, including director, teacher, cottage parent, psychologist, caseworker, handyman, and maintenance worker.

SOCIAL WORK PRACTICE IN COMMUNITY ORGANIZATION. Helen D. Green. Foreword by W. I. Newstetter. Whiteside, Inc., and William Morrow & Co., New York. 1954. 253 pp. $4.

"Social intergroup work," a process directed toward satisfactory and productive relations between groups, is the aspect of professional social work in community organization emphasized in this book. Development of social intergroup work has only begun, and this book is an initial attempt at defining what it is.

The author lists three essentials: a structure which implements the process; a focus on social goals selected and accepted by the groups involved; application of social-work philosophy, knowledge, objectives, and skills.

Two-thirds of the pages are devoted to recording the practical process of social groupwork in three different settings.

COMMUNITY ORGANIZATION PRACTICE. Campbell G. Murphy. Houghton Mifflin & Co., Boston. 1954. 444 pp. $4.50.

A textbook for community-organization courses, this work discusses the concept of community organization, relevant principles of social work, the knowledge and special skills community organization requires, and the application of both in coordinating, promoting, and giving direct service.

THE COMMUNITY AND THE DELINQUENT; cooperative approaches to preventing and controlling delinquency. William C. Kvaraceus. World Book Co., Yonkers, N. Y. 566 pp. $4.50.

Among all the community agencies that work to prevent and control delinquency, the author believes the school plays the central role. The superintendent of schools, he says, "can either stimulate or stifle the concerted community attack on juvenile delinquency."

KNOW YOUR CHILDREN IN SCHOOL. Edited by Lucy Sprague Mitchell. Macmillan Co., New York. 1954. 188 pp. $3.

This book presents word sketches of real children in real schools, gathered by the Bank Street College of Education to show personality differences and problems, and to suggest possible solutions.

Sketches are based on kindergarten to sixth-grade records made in the Bank Street Workshops in public schools in New York City, a form of in-service training for teachers sponsored by the city board of education. Parents as well as teachers should gain from the presentation.

PROJECTS AND PROGRESS

Tenth Pan American Child Congress

Meeting for the first time with the status of a Specialized Conference of the Inter-American System under the Charter of Bogotá, the Tenth Pan American Child Congress was held in Panama City, February 6 to 12, 1955.

Despite the fact that this Congress had been postponed following the tragic assassination of President Remón of Panama, more than 200 delegates from 19 of the American Republics (all but Bolivia and Mexico) registered.

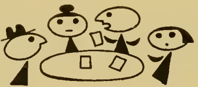
The official United States delegation included 11 representatives of the Government and of private organizations. In addition, there were 32 registered observers, including representatives of the governments of Spain, France, Italy, and also of the Holy See. Official observers came also from the Organization of American States and some of its specialized organizations, such as the American International Institute for the Protection of Childhood, the Pan American Sanitary Bureau—WHO's Regional Office for the Americas—and the Inter-American Statistical Institute.

The Pan-American Congress was also attended by observers from the United Nations, UNESCO, UNICEF, the UN Economic Commission for Latin America, and international organizations of a voluntary character such as the International Conference of Social Work, the International Catholic Social Service Union, and the World Union of Catholic Women's Organizations.

A distinguishing characteristic of these Congresses is their interdisciplinary character. Ever since the first Congress met in Buenos Aires in 1916, work has been carried on through technical sections dealing with all aspects of child life. The Tenth Congress was divided into 5 sections: I. Health (including Pediatrics and Maternal and Child Health Services); II. Education; III. Social Services; IV. Sociology and Legislation; and V. Inter-American Cooperation.

No previous Congress approved so small a number of resolutions. The total of 25 included 7 in the field of health; 5 in education; 4 in social welfare; 3 in sociology and legislation; 3 in inter-American cooperation; and 3 miscellaneous.

The Health Section was particularly concerned with the lack of vital statistics. Training of experts in this field was defined as a basic need, and the American countries were urged to make full use of all available training facilities to increase the number of qualified statisticians. The American International Institute for the Protection of Childhood was urged to continue its preliminary work in this field in consultation with the Inter-American Center of Bio-Statistics, established in Chile by the United Nations and in line with recommendations of Pan-American Sanitary Conferences. Special attention was directed to the needs of crippled children, the training of experts for their care and treatment, and to the problem of child nutrition. Other resolutions dealt with the organization of health services, and of day-care centers.



Each country participating in the Congress had been invited to prepare a basic paper on one specific topic. That assigned to the United States was books and magazines for children, including "the comics." This paper was prepared by the U. S. Office of Education in consultation with other groups and agencies. A resolution developed by the Education Section on this subject urged that well written and illustrated reading matter be made available for different age groups and at reasonable cost; that committees or groups in various countries be established or strengthened to bring about needed improvements; and that library services be improved.

All sections of the Congress were concerned with improving services in rural areas. Section III asked schools of social work to take the lead in training auxiliary workers as well as experts to supervise such workers. It recommended that, where national programs so require, special schools or courses be established to train social workers for rural areas.

Sections III and IV gave considerable emphasis to family welfare and to laws and services to strengthen the economic and social bases of family life, aid in prevention of juvenile delinquency, and provide better treatment facilities for delinquents. It was obvious that the 20 other American Republics are just as concerned with the problem of juvenile delinquency as the United States.

Responsibility for assisting the 21 American Republics in carrying out recommendations of the Child Congresses rests upon the American International Institute for the Protection of Childhood, headquartered in Montevideo, Uruguay, to which the United States has belonged since 1928. Member governments were urged to give increased support to the institute. It, in turn, was directed to draft a new plan for extending its activities, to be submitted to member governments for approval, and to avoid duplication of effort of other international and inter-American organizations.

Delegations to the Congress included outstanding professional experts in the fields of health, education, social work, law, and public administration.

Elisabeth S. Enochs, Chairman of the United States Delegation.

National Conference on Adoption

Social agencies took what was probably the broadest and deepest look at problems and practices in adoption that has ever been taken in this country, at the National Conference on Adoption, which met in Chicago January 26–29 under the sponsorship of the Child Welfare League of America.

The League, which is making a nationwide study of adoption practices, planned its Conference so that child-welfare agencies could exchange knowledge and experience with outstanding specialists in many fields other than social work. More than 300 persons took part, representing, besides social work, the fields of anthropology, genetics, law, psychology, religion, sociology, and several specialties of medicine.

Eight central aspects of adoption were examined in separate technical sections of the Conference: heredity in relation to the child considered for adoption; factors in adoption placement; adoption of older children and children with special needs; selection of adoptive parents; the needs of the child's natural parents; the law and adoption; community services for children in need of adoption; and criteria for predicting successful adoption.

Throughout the discussion the interests of all three parties involved—the child, his natural parents, and his adoptive parents—were kept in focus.

Adoptions have reached such proportions that public as well as voluntary services are needed to help meet the needs of the three, the Conference pointed out. More and more is becoming known about the kinds of services needed. The social agency is now clearly seen as the framework within which many persons and many professions can and must work as a team for successful adoptions.

Over and over again the discussion showed how social agencies are challenging, testing, and modifying their practices. Many agencies reported that they now place babies for adoption much earlier than they used to—some at 1 to 6 weeks of age. Advantages and risks of early placement were looked at from many points of view. A physician remarked that adoptive parents are best helped when they can have a child as soon as possible: "the nearer we get to biological parenthood the better." Placement by the age of 3 months, unless circumstances call for longer observation of the child, was advanced as a general goal.

A number of participants emphasized the need for flexibility in the timing. They reminded the group that the time span is shortened when natural parents are known to an agency and a firm decision on relinquishment of parental rights can be reached early. But the needs of the natural parents—usually the mother—must always be weighed. With many unmarried mothers, plans for both mother and child can now be worked out earlier than formerly, it was reported, because care of mothers in maternity homes has become more flexible. Workers in this field held that adoption services should regularly include services for the natural parents—not alone for the child and the adoptive parents. Both medical and social services are needed for mother and child. If the mother is unmarried, casework services should be given early.

A psychiatrist emphasized the values of early placements. In the past, resistance to early placement has resulted from the fear that a mother's decision to relinquish her child will be too hasty, and from the desire to have more time to assess the baby's potential. As for predicting a baby's future development, this psychiatrist felt that the best guide is the agency's information on the natural parents' intelligence and that based on observations by the pediatrician and the caseworker. When there is a question on a baby's background, a medical geneticist may be able to help with an opinion.

Today's agencies, it was noted, tend to probe their own work, to make use of new knowledge available from research in such fields as genetics and anthropology. They are alert to the need for research in all aspects of adoption and for identifying specific aspects on which research is needed to develop criteria for predictability of the success of adoptions. But several participants warned social agencies that this kind of research has limitations and that the contributions of experience should never be underestimated.

Changes in ways of selecting adoptive parents were also reported. Agencies are not now so likely to seek the perfect adoption, as they once were, to "match" superficial factors in the child with those of the adoptive parents. Nor do they pay so much attention to external factors, such as neatness of the adoptive home. Instead, they take on the more difficult task of seeking emotionally mature couples who can accept a child wholeheartedly, warmly; who are able to change, to take risks; and who are able to "grow into parenthood."

The questions now are more likely to be: Are both husband and wife emotionally mature? Are they realistic in what they expect from an adopted child; that is, do they expect no more than they would find in a child who had been born to them? Have their lives been relatively free of emotional problems? Have they made every effort to get the best medical help to have a child of their own?

Since childlessness may be the immediate reason why a couple seeks a child to adopt, the causes behind their childlessness should be studied, one psychiatrist stressed. A gynecologist described present-day work in combating infertility.

Adoption of children over 5 years of age, handicapped children, and children in minority groups was known to all participants as a difficult problem. It was agreed that caseworkers hoping to place such children need to seek and learn to use specialized help.

Public attitudes, like agency practices, have changed during the last decade, a speaker pointed out. With the present great demand for children, couples who have adopted a child are proud of the fact and are not likely to be secretive about it. Many people also take a somewhat more tolerant attitude toward children born out of wedlock, who represent about half the children placed for adoption. But this whole problem is still little understood by the public, and a participant said that even social workers sometimes plan with an unmarried mother without realizing what she must face in her own community. Many social agencies are working to bring about better public attitudes toward unmarried mothers, it was reported.

Conscious of the responsibility borne by anyone who makes the decision on placement of a child—as one said, "the social worker is playing a God-like role, for she determines the destiny of a child"—social workers were reassured that constant examination and reexamination of their methods of working will make the risk of poor jobs "less and less, as we go on."

A complete report of the Conference will soon be made available by the League.

White House Conference on Education

Each of the States and Territories has taken official action on State conferences to prepare for the White House Conference on Education, which will be held November 28 to December 1, 1955, at Washington. The Conference was authorized by the 83d Congress in response to President Eisenhower's appeal for a national study of this country's educational ills. He recommended that all the States and Territories hold conferences on education, which would culminate in a national conference.

By the end of April 1955, Wyoming, Nebraska, Washington, Connecticut, Kansas, Iowa, South Dakota, Pennsylvania, and Hawaii had already held their conferences, and 30 other States have scheduled conferences to be held before November of this year.

The governors of most of the States have applied to the Commissioner of Education for funds to finance their State conferences; these funds are allotted according to population.

The Committee for the White House Conference on Education, appointed by President Eisenhower, has recommended six topics for discussion by educators and lay citizens at the State conferences and the Washington general session. These are: What should our schools accomplish? How can we organize our school system more efficiently and economically? What are our school-building needs? How can we get enough good teachers—and keep them? How can we finance our schools—build and operate them? How can we obtain a continuing public interest in education?

Each topic is now being studied by a subcommittee of the national committee, and their analyses will be sent in advance to participants in the White House Conference for discussion at the national meeting.

Each State conference will report its findings and recommendations to the national committee, which, after the White House Conference, will report these to the President, along with the results of the Conference and the committee's own findings.

Recognizing that no planning for education is complete without consideration of the health needs of the child in the school environment, health departments and medical societies in a few States are already participating in the work of the conference committees.

Already followup activities for 1956 have been planned by Nebraska, Iowa, Kansas, Connecticut, and Pennsylvania.

Delinquency

Two hospital departments of pediatrics in Philadelphia recently sponsored a seminar on juvenile delinquency, featuring a panel discussion by various agencies concerned with the problem and drawing an attendance of some 300 persons. The seminar, one of a series held regularly by the pediatric staffs of the Hospital of the University of Pennsylvania and the Children's Hospital of Philadelphia, centered about the case of a 10-year-old delinquent boy whose physical symptoms of ill health grew out of his emotional conflict in being a member of a fighting gang. The case presentation led to a consideration of the various community and personal factors leading to delinquency and ways of dealing with them.

Panel participants included the directors of two child-guidance clinics, the executive director of a citizens' crime-prevention association, the director of pupil personnel and counseling of the local public schools, and the chief of the maternal and child-health section of the city department of health.

Home Economics and Child Study

To explore the question of how opportunity for experience with infants can best be provided for students preparing to be home economists, 21 specialists in various fields from over the country met at Washington February 3–5, 1955, with representatives of the Home Economics Branch, Office of Education, and of the Children's Bureau. These specialists, representing the fields of psychiatry, psychology, child development, home economics, social work, health, education, and research, came together at the invitation of the Deputy Commissioner of Education and the Chief of the Children's Bureau.

The group agreed that all people who work with children need a common core of knowledge; they need to *know* children as well as to know *about* children; their knowledge should include an understanding of child development and of parent-child relationships in normal situations, as well as in problem ones; this knowledge and understanding have to be gained through practical experience. The group discussed (1) goals in the preparation of home economists which call for an understanding of infant development; (2) ways of effectively developing this understanding; (3) findings of research on infant development; and (4) principles which should govern experience with infants in the education of home economists.

After discussion, the conference membership divided into three committees on (1) basic principles, (2) ways of providing experience with infants, and (3) next steps to be taken. Findings of the committees were later discussed by the total group.

The statement on principles recognizes the field of home-economics education as one of basic social significance, affecting, as it does, the character and quality of family life; and experience with infants and other children as a significant part of the education of students in this field, because of the contribution it makes to learning and to social understanding. The principles further emphasize that, in providing these experiences, care should be taken to safeguard the physical and emotional growth needs of children; to evaluate the meaning of the experience for infants, for students, and others concerned; to determine the roles of various disciplines, in planning and operations; and to preserve the identity and integrity of schools of home economics as responsible educational agents.

The report on ways for students to gain experience with infants and children stresses the importance of flexibility and variety of experience, adapted to specific situations. Some suggested types of experiences are: visiting in family homes; working with staffs of other agencies; participating in the program of infant laboratories and home-management houses, with varying arrangements. Continual review of plans and adequate professional supervision are considered essential.

The statement of the group on "next steps" recommends extensive research on infant development in a variety of settings and kinds of mothering; and on the effectiveness of the educational process for students having *supervised* experience with infants in these settings. Pending completion of these studies, the report suggests close and continuing cooperation by those concerned in this planning, especially at the State and local levels.

A full report of the conference will be available at a later date.

Epilepsy

Children with epilepsy can look forward to better adjustment in society when recent medical discoveries are translated into law. This is made clear in the report of a special committee on legislation of the American League Against Epilepsy, which recently surveyed State laws affecting epileptics.

The right to operate a motor vehicle is of great importance in the adjustment of the epileptic, says the committee. Depriving him of this right creates a serious psychological obstacle to his orientation in society and deprives him of job opportunities. Many State laws are so worded that as administered they deny a license even to epileptics who have rendered seizure-free and are thus capable of driving safely. The committee recommends that certain laws and administrative procedures be amended so that persons whose seizures are under effective and continuous control, as certified on sound medical judgment, will be granted limited licenses, subject to renewal on the same ground. Wisconsin's statute and administrative procedure are cited as successful.

Since the family is the basic unit of society, limitation of the epileptic's right to marry is a formidable obstacle to his adjustment, says the committee. Seventeen States prohibit marriage of epileptics, apparently on the ground that epilepsy is a strongly hereditary condition and in the mistaken belief that it is a form of feeble-mindedness. In view of the low incidence of inheritance of the tendency to seizures and the minimizing of their disabling effects through medical control the committee recommends that eugenic marriage laws be amended to make the prohibitions inapplicable to epileptics. Similar amendment is recommended in regard to sterilization laws.

Employment, says the committee, is the *sine qua non* in the rehabilitation of the epileptic. One of the reasons employers refuse to employ epileptics is the belief that epileptics are more prone to accidents than other employees, a belief that the committee considers highly questionable. If this excuse for denying employment to epileptics is to be avoided, the committee says, it will be necessary to amend the workmen's compensation laws so that the employer will be exempt from liability for injury to, or by, an epileptic, which was caused by the epileptic condition.

The survey was made possible through a grant from the National Institute of Neurological Diseases and Blindness, National Institute of Health, Public Health Service, Department of Health, Education, and Welfare. The report is as yet unpublished.

Rheumatic Fever

A "Stop Rheumatic Fever" campaign is being launched throughout the United States to save the lives of thousands of children and young adults and to prevent damage to their hearts. Based on control of streptococcal infections, which may precipitate rheumatic fever, the program is being conducted by the American Heart Association and its affiliates in conjunction with the National Heart Institute of the United States Public Health Service.

To assist in developing community "Stop Rheumatic Fever" programs, the Heart Association and the Heart Institute are making available through local heart associations and health departments a variety of educational materials for the general public. At the same time the Heart Association is sending the latest medical information on techniques of prevention of rheumatic fever to more than 100,000 physicians throughout the country.

Various materials are available from local heart associations and health departments as well as from the American Heart Association, 44 East 23d Street, New York 10, N. Y., and the Heart Information Center, National Heart Institute, U. S. Public Health Service, Bethesda 14, Md.

Here and There

Through a rheumatic fever program begun recently by the Heart Association of Maryland and the Maryland State Department of Health, children and adults with rheumatic fever who cannot pay for medical care are receiving free drugs to prevent repeated attacks. The drugs are the new long-acting penicillin tablets, to be taken under the direction of physicians at State-approved cardiac clinics.

To be eligible to receive the free drugs patients must be under 18 years of age and have a well-established history of rheumatic fever or rheumatic heart disease, or if over 18, must have had an acute attack within the past 5 years. Persons enrolled in the program will take the drugs daily over a period that may last as long as 5 years.

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In Massachusetts an increasing emphasis in the State Department of Public Welfare on helping children in their own homes has been fortified by a 1954 law setting a State policy on placement outside the home. Under this policy placement is made "to provide substitute care of children only when the family itself or the resources available to the family are unable to provide the necessary care and protection. . . ."

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Alaska's Department of Public Welfare recently issued new standards for licensing child-caring institutions. The standards were developed at the Department's second conference with staff members of all the institutions to discuss ways of understanding and meeting the needs of the children. The Department is planning to continue this type of conference at regular intervals.

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Twenty-seven nurses have been enabled to return to work at St. Barnabas' Hospital, Newark, N. J., through use of a day nursery for nurses' children, in a building on the hospital grounds. Fourteen of the 27 nurses now give full time to nursing at the hospital; the rest part time. The hospital established the nursery in a frank effort to solve a staff shortage by luring former employees back to work. The nursery attendance sometimes runs as high as 24; the daily average is 8.

IN THE JOURNALS

Prenatal Care

To recognize that a woman has a markedly immature, dependent, and infantile personality will in the future be as relevant at prenatal examination as it now is to recognize a contracted pelvis. This was stated by C. R. Hargreaves, O. B. E., M. R. C. S., Chief of the Mental Health Section, WHO, at the 1954 International Congress of Obstetrics and Gynecology, reported in the *Lancet*, London, for January 1, 1955.

By the time a psychiatrist sees such a patient, she can be helped, often, only by extensive treatment, the speaker said. The obstetrician and the obstetric nurse, on the other hand, see the woman early, when simple measures sometimes can tip the scale in the right direction.

The psychiatrist can help to prevent many ills due to the emotional stress of childbearing on vulnerable personalities by teaching obstetric workers techniques for helping the pregnant woman, he added. Often obstetric workers can relieve the unnecessary emotional anguish that a new mother suffers, sometimes because no one has told her what feelings are normal.

Child Labor

Defending child-labor laws against a charge that they encourage delinquency by preventing youngsters from getting jobs, Virginia's child-labor committee, in *The American Child* for March 1955, suggests that State figures be obtained to answer two questions: (1) How many children still attending school have been delinquent in the past 2 years? (2) How many children released from school at 14 or 15 as unable to profit from further school attendance were delinquent before they were released from school, and how many became delinquent after their release?

The committee made the suggestion at a hearing before the Virginia Juvenile Delinquency Study Commission, testifying also that the child-labor law needs to be interpreted better to agencies concerned and to the community. Noting that thousands of children drop out of high school each year, the committee urged that the schools try to get these children to stay in school voluntarily.

The National Child Labor Committee, which publishes *The American Child*, says that attempts to make the child-labor laws the scapegoat for the delinquency problem are evident in many States besides Virginia.

Hazards in the Home

A physician faced with the necessity of treating a child who has swallowed a paint solvent, or a furniture polish, or a household cleanser, often has no way of knowing what ingredient is causing the trouble. In the *Journal of Pediatrics* for March 1955, Morton J. Rodman, Ph. D., summarizes information obtained from several hundred manufacturers on the ingredients of products often used in homes. (Possibly on account of the "do-it-yourself" boom, says Dr. Rodman, many chemicals formerly used only in industrial plants are now brought into homes, where the hazards are not understood.) Many materials are safe when used as directed, Dr. Rodman explains, but dangerous when they get into the hands of children. For such products he urges precautionary labeling. The label need not frighten the public with the word "poison," he says. But it should tell parents to keep the product away from children. And for the information of physicians, the label should list any potentially poisonous ingredients. More important even than adequate labeling, Dr. Rodman suggests, is further education on harmful potentialities of many products. Such education should reach not only the public, but also the manufacturer, the physician, the pharmacist, and others.

Dentistry for the Retarded

Dentists should acquaint themselves with a retarded child's mental level before treatment, Jerry J. Adelson, B. S., D. D. S., says in the *American Journal of Mental Deficiency* for January 1955. Many children can be treated in the usual way, but others require diagnosis and treatment under highly specialized conditions, employing new techniques, which the author describes. A complete physical check-up by a pediatrician is also needed before diagnosis and treatment, and the history should be made available to the dentist. Telling what parents can do to prepare the child for dental treatment, Dr. Adelson also offers suggestions on overcoming, without distressing the child, opposition to brushing teeth.

Adoptions

The most neglected aspect of adoptive placement, according to Florence G. Brown in *Child Welfare* for March 1955, is the time between the placement of the child in the adoptive parents' home and the legal action that makes him a permanent part of the family. During this period the social agency still has legal custody of the child, and Mrs. Brown urges that the staff recognize the importance of its role in helping the child and parents grow into a family unit. "It is no reflection on a worker nor on an agency," she says, "to find that there are problems after placement and that help is needed. We are subject to criticism only if we are not aware of what is happening or are so afraid to face the fact that our selection was not a good one that we just close our eyes to the problems that occur after placement."

Pediatric Nurses

Nursing students are likely to lose their enthusiasm for pediatric nursing after 3 months' experience with sick children, reports Ruth Frank Baer in *Nursing Outlook* for February 1955. Results of projective tests and other evidence, gathered from seniors at the University of Illinois School of Nursing, point to diminishing returns in the students' enjoyment of their work. This change takes place not only because sick children often are angry or unhappy much of the time; nor because a child may hate the nurse when she is giving him painful treatments. It is more than that; many students finish their pediatric course with an insecure feeling about their ability to meet situations in child care. Mrs. Baer suggests that 3 months may be too short a time for a person to learn how to meet "the total needs of the child."

READERS' EXCHANGE

OPLER: Many streams influence

Dr. Opler makes the excellent observation that a knowledge of culture values is essential to the proper understanding of the behavior of the individual who holds those values. ("Cultural Values and Attitudes on Child Care," CHILDREN, March–April 1955). . . .

I would like to emphasize another point that is implied by Dr. Opler's paper. This is the danger of assuming that specific behavior can be related on a one-to-one basis either to isolated values or to isolated value conflicts. . . .

For example, a common experience of Italian-American boys of a certain description is that their fathers pressure them to take a "good, steady job" early in life at the sacrifice of higher education. This produces conflict in that it contravenes the American emphasis on the desirability of education as a factor in attaining the goal of upward social mobility.

To understand the real significance of the rebellion of such a boy against this paternal expectation, one must take into consideration the nature of the family solidarity, the standards of masculinity, peer group relations, financial obligations, sibling relations, and the basis of authority in the family. This certainly doesn't exhaust the list, but it does give an idea of how a specific act is at the confluence of many streams of influence most of which are reflective of underlying cultural values.

Paul Barrabee, Ph. D.,
Boston, Mass.

Transmitted attitudes

Dr. Opler has effectively presented the view that child rearing practices, while neither determining nor moulding the personality, represent a channel through which the cultural background becomes a part of the individual. . . . Material from recent studies shows the persistence of implicit and nonverbally communicated attitudes into the second or third generation of American citizens. . . .

I take issue with Dr. Opler over his picture of the Hopi. It is true that the individual ends coincide with group ends and even with the ends of the entire universe; yet this does not mean suppression of the individual. Within this framework, the individual, whose every act and thought and wish ultimately affect the universe, has tremendous significance; he is unique in his role, and he is non-interchangeable.

Dorothy Lee
Anthropologist, Merrill - Palmer School, Detroit

HUNT: How overcome inertia?

It was extremely gratifying to see Dr. Hunt's article ("Getting at the Facts of Infant Losses," CHILDREN, January-February 1955). The fetus and infant are at last being recognized as the reason for pregnancy and not a by-product; their failure to survive, as caused by specific pathologic processes and not by some vague chimera often considered "an act of God."

All the evidence points to the fact that the judgment and skill exercised by the physician during labor and delivery are the primary factors determining the level of mortality rates. Prenatal care is of value in that it makes it possible for the physician to do a better job when the patient is in labor; it may be life saving for the mother and consequently for the fetus, but aside from this there is little evidence that prenatal care does much to affect the fetus in utero or the infant after birth. . . .

How are we to prevent prematurity? Giving better care to expectant mothers is certainly desirable, and giving better care to the mother at the time of delivery is going to give her premature baby a better chance of living but it isn't going to prevent prematurity. At the Chicago Lying-in Hospital, in spite of having a large majority of cooperative, socioeconomically satisfactory patients, with advice on diet and hygiene constantly available in addition to good medical attention, our premature births make up between 6 and 7 percent of the total deliveries year after year.

My plea, in writing this letter, is to urge that large sums of money *not* be spent in hiring people to go to hospitals and transcribe data which are analyzed in a central bureau. And that the end of this not be a paper appearing in the State medical journal telling the doctor he ought to prevent certain conditions.

If an equivalent amount of money could be spent in stimulating the physicians in all hospitals, even the smallest, to discuss the situation surrounding the pregnancy and birth of every dead fetus or infant who fails to survive, and to have an autopsy on each one (for only in this way can there be any real assurance as to why many infants are lost), far better results might be obtained.

The collection and local tabulation of such data are of great personal value. If the physician will not participate in such a program it is very unlikely he will benefit by reading a paper on the subject written by someone else.

The real problem that faces us is how to overcome inertia.

Edith L. Potter, M. D.,
University of Chicago Department of Obstetrics and Gynecology, Chicago Lying-in Hospital

ROBINSON: How evaluate?

The "Team Approach in Preventing Maladjustment" (CHILDREN, March-April 1955), discussed by Marion Robinson, describes a much-needed step in community efforts to break the vicious circle of personal problems and family disorganization. There can be no quarrel with the attempt to deal with the family as a whole, and to avoid the all-too-familiar situation of agencies trying to serve particular needs of individual family members while the ground is cut out from under their efforts by other elements in the family situation. . . .

The questions which the article leaves unanswered relate to three points: (1) The actual research techniques by which the preventive effects of the projects are to be assessed, (2) the steps planned to make sure that the work is carried forward by the community when the "research project" is terminated, and (3) proposed ways of enabling other communities to profit from the experiments.

The brevity and generalized character of the article may be responsible for leaving these crucial points unclear. Or it may be that these projects are not, in reality, research projects, but experimental, demonstration programs using the vehicle of "research" to induce changed relationships and procedures which would be more difficult to achieve by a direct approach. Since, however, the problem of how to evaluate the preventive effects of welfare programs is one which still baffles the social work profession, and since the road to improved welfare services is strewn with fine experiments that petered out when outside support was withdrawn or failed to spread beyond their initial locale, it is to be hoped that a later article will discuss these aspects of the potentially valuable projects which Miss Robinson's article describes.

Caroline F. Ware
Howard University School of Social Work, Washington, D. C.

"Social breakdown" revamped

I see by Marion Robinson's article that "social breakdown" has changed its name and is now to be recognized as disordered behavior. . . . It seems to me that most of the same objections that have been voiced earlier to the social breakdown approach beginning with the publication of "Social Breakdown," by Bradley Buell in 1939 are still applicable and valid. . . . For an incisive analysis of the general framework and philosophy within which the three projects described are planned, and of some of their implications for social work practice, the interested reader is referred to Harry Lurie's brilliant article, "Community Planning for Human Services," in the February 1953 issue of *Child Welfare*.

The curious notion exists that the counting of the number of families in six selected categories, more or less legal in their nature, constitutes the basis for the measurement of the size and shape of the community's total maladjustment problem. The issue here is not an esoteric, technical one for researchers to quibble over, but has direct meaning for concepts of human needs and problems, and for how our resources should be developed and organized to meet them.

It is easy to agree that we need better health and welfare planning, more effective integration of services and professions, and much more knowledge about diagnosis and treatment. But what is the relation between those "needs" and the social breakdowners' notion that health and welfare services should be organized around and focused primarily and seemingly almost exclusively upon a presumed "hard core of human misery." None of the facts circulated thus far *re* a small percentage of families securing a large proportion of health and welfare services makes such a notion logically valid. . . . Moreover, these facts on critical analysis lose most of such meaning as they seem to have, since they are derived from inadequate and inconsistent conceptions of need and need-meeting institutions.

It does not seem precisely clear as to what is being tested against just what in the experiments. Obviously, however, the methodological problems in any such undertaking are tremendous in their scope and difficulty. The projects will undoubtedly be followed with a great deal of interest, and it is to be hoped that the findings will help in obtaining answers to questions that are highly significant for us all.

Elbert L. Hooker
Professor of Social Research, School of Social Work, University of Pittsburgh

The meaning for services

We are indebted to Bradley Buell and his associates for their widely separated community studies which suggest that a relatively small proportion of agency clients receive a disproportionate amount of the service offered. As Marion Robinson has pointed out in her article about their work striking similarities in the size of this group of clients from community to community would appear to give evidence that the "hard core" now has statistical confirmation.

The existence of this "hard core" should be disturbing to the complacency of caseworkers, health officers, and community organizers.

Some of us of long experience in community planning are inclined to challenge the feasibility and desirability of the central diagnostic service as a permanent part of the community's social service structure. While it may have acceptance in an experimental venture backed with ample financing, it seems to lack realism as a form of permanent organization. . . .

Robert H. MacRae
Executive Director, Welfare Council of Metropolitan Chicago

FOSTER: Isolation from peers

Apropos of Miss Foster's article ("Stabilizing Influences in Helping Handicapped Children," CHILDREN, March–April 1955), a common problem, in many communities, has been the lack of adolescent wards in hospitals and the absence of convalescent care facilities geared to the needs of older boys and girls. The adolescent with a cardiac condition, for example, may need such resources as much as the older child with an orthopedic condition. Too often, children over 12 or 14 years requiring hospital or convalescent care have had only adult medical facilities available to them. Isolation from peers during hospitalization or convalescence has been known to create new problems and retard the adolescent's progression toward adult life.

Further articles dealing with the creative use of an institutional experience to enable the adolescent sick or disabled child to grow toward the goal of adult rehabilitation might well stimulate development in communities where such facilities are meagre or nonexistent. It would also be helpful to have more literature which is written from the combined approach of the social caseworker and the social group worker in the medical setting which provides rehabilitative services to adolescent boys and girls.

Caroline H. Elledge
Chief Social Work Consultant, New York City Department of Health

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SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

THE TEACHER AND MENTAL HEALTH. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health. PHS Pub. 385. Prepared by the National Institute of Mental Health. 1954. 20 pp. 15 cents.

The teacher's supportive role in helping the child meet his emotional needs, according to this booklet, presupposes knowledge of the dynamics of mental-health principles. The booklet offers some information of this kind and, as resources for additional information, lists titles of books, pamphlets and reprints, and films.

WHEN THE MIGRANT FAMILIES COME AGAIN; a guide for better community living. Federal Interdepartmental Committee on Children and Youth. 1954. 27 pp. 15 cents.

This committee, representing 30 Federal agencies, offers in this illustrated bulletin "ideas and suggestions rather than a prescription" for communities annually visited by migrant farm workers. Their needs, ways of working with them, what agencies and individuals can help, printed material that may be helpful, and a "Guidesheet for a Community Starting to Plan" are set forth. Effective projects in five communities — Hollandale, Minn., Hoopeton, Ill., Cayuga County, N. Y., San Antonio, Tex., and Fresno, Calif.—are described.

THE EFFECTIVENESS OF DELINQUENCY PREVENTION PROGRAMS. Helen L. Witmer and Edith Tufts. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, CB Pub. 350. 50 pp. 25 cents.

As an aid to professional workers and citizens groups in evolving new prevention programs, the authors evaluate here studies that have been made of past programs. They find these studies provide few definite conclusions as to what works and what does not work in reducing delinquency. On the plus side, however, they believe a start has been made toward identifying the kinds of measures likely to lessen delinquent acts by some types of children, and point to some new measures, recently devised, to reach children who did not respond to old methods. They appeal to planners to build research into programs from their start.

THE SOCIAL WORKER'S ROLE IN MENTAL HEALTH. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health. PHS Pub. 351. Prepared by the National Institute of Mental Health. 1954. 12 pp. 10 cents.

The psychiatric social worker, the family caseworker, the child-welfare worker, the social worker in the public-assistance agency, the medical social worker, the parole and probation worker, the school social worker, and the social worker in community organization for social welfare—each of these has many opportunities to promote mental health, says this booklet, which ends with the words: "No matter what the setting in which the social worker operates, he or she is in a very real sense an integral part of the mental-health movement."

THE SCHOOL LUNCH—ITS EDUCATIONAL CONTRIBUTION. U. S. Department of Health, Education, and Welfare, Office of Education. Nutrition Education Series, Pamphlet No. 6. 1954. 27 pp. 25 cents.

A revision of Pamphlet No. 2 in the same series, published in 1944, which was entitled, "Making School Lunches Educational."

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JULY · AUGUST 1955

A PROFESSIONAL JOURNAL ON SERVICES FOR CHILDREN AND ON CHILD LIFE

A TWENTY-YEAR PERSPECTIVE ON SERVICES TO CHILDREN

developments in child health and welfare since the passage of the Social Security Act

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Before assuming his present position in the New York State Department of Health, Dr. Edward R. Schlesinger was director of its Bureau of Maternal and Child Health. Author of "Health Services for the Child," published by McGraw-Hill in 1953, he has also written numerous professional papers on premature infants, rheumatic fever, cerebral palsy, and other problems affecting child health. He is an associate in pediatrics at Albany Medical College.

From the time of his residency at the Boston Lying-in Hospital, Dr. Samuel B. Kirkwood has been interested in the public-health aspects of obstetrics. In the same year he established practice in obstetrics in Boston he was appointed to the staff of the Harvard School of Public Health. Though he left private practice on taking his present position 2 years ago, he has continued his hospital-staff work and his teaching as a clinical professor of maternal health.

A graduate of Stanford Medical School, with pediatric training received in San Francisco, New York, and Baltimore, Dr. Edward Davens now heads a Maryland bureau which includes the State's crippled children's maternal and child-health, mental and dental health, and nutrition services. He lectures at the Johns Hopkins School of Hygiene and Public Health and serves on WHO's Expert Panel on the Physically Handicapped Child.

A former dean of the School of Applied Social Sciences and vice president of Western Reserve University, Leonard Mayo was chairman of the executive committee of the Midcentury White House Conference on Children and Youth. He has been president of the National Conference of Social Work and of the Child Welfare League of America.

Norris Class, who now teaches social-work students about the origin, development, and administrative organization of American social-welfare programs, was director of child welfare in Oregon when that State was organizing its Federal-State child-welfare program. A graduate of the school of social work at Western Reserve University, he was once county child-welfare worker in Cuyahoga County, Ohio.

For the past 25 years Anne E. Geddes has been engaged in research on public assistance. From 1938 to 1954 she was Chief of the Division of Program Statistics and Analysis, Bureau of Public Assistance, Social Security Administration. In her present associations she is continuing to do research in the field of public assistance.

frontispiece

"It must not for a moment be forgotten that the core of any social plan must be the child. Every proposition we make must adhere to this core."

—Report of the Committee on Economic Security, January 15, 1935.

Photo by Eva Luoma.

A TWENTY-YEAR PERSPECTIVE ON SERVICES TO CHILDREN

MARTHA M. ELIOT, M. D.
Chief, Children's Bureau

TWENTY YEARS AGO, on August 14, 1935, the Congress took a major step in behalf of the Nation's children when it restored and expanded its earlier program of grants to the States for health services for mothers and children, and provided for additional health and welfare services.

Congress' first effort to assist the States, the Maternity and Infancy Act of 1921, had been limited in time to the years between 1921 and 1929, and in coverage to health care in the maternity and infancy periods. Restoration of this program had been advocated for a number of years by civic and professional organizations and individuals concerned with the serious health conditions affecting child life. The beginning of the great depression in 1929 had been coincident with the withdrawal of these grants.

In the fall of 1934, the work of a Cabinet Committee on Economic Security was nearing completion. Proposals for Federal legislation to establish programs of social insurance against loss of income due to age, unemployment, illness, or disability, and financial assistance for the needy aged were under discussion with technical committees. At about this time the desirability of including in its proposed omnibus bill measures that would strengthen State health services generally and the maternal and child-health services in particular became apparent. Therefore, the Committee asked the Public Health Service and the Children's Bureau to prepare material in their respective areas of concern. With the help of an advisory committee especially formed for the purpose, the Children's Bureau responded with proposals which ultimately formed the basis of two titles of the Social Security Act, passed by Congress that memorable August 14. These not only restored the maternal and child-health program, this time without limitation on the age of children or duration of the program, but also accepted Federal responsibility for helping to meet other kinds of need among children in the welfare as well as health fields.

In gathering information for the Cabinet Committee to use in support of its proposals on behalf of children, the Children's Bureau had been able to turn to many reports that bore testimony to the need for action in the child-health and welfare fields. Though our national infant mortality rate had been falling, it was still considerably in excess of the rates in countries with the best records. As a result of 5 years of economic depression there was much malnutrition including serious protein and vitamin deficiency among children. Infectious and communicable diseases were still taking too high a toll of infants' and preschool children's lives.

Studies made by the Children's Bureau and reports from many voluntary organizations had shown that large numbers of crippled children were going without care in many States, especially in rural areas.

And yet the knowledge and skills existed in many medical centers that would save thousands of children from going through life severely handicapped or even entirely incapacitated if they could be made available to the children who needed them.

Progress and Resources

On the plus side was the work of the Society for the Prevention of Infant Mortality, predecessor of the American Child Health Association. There was also a wealth of material for the use of professional health and welfare workers which had been brought together by the White House Conference on Child Health and Protection in 1930. That year, too, saw the establishment of the Academy of Pediatrics with its basic objective of "correlating all aspects of work for the welfare of children which properly come within the scope of pediatrics." This meant that prevention of disease and a positive approach to child health and welfare as well as the application of new knowledge in treatment were becoming more and more common in pediatric practice.

In those years too, modern concepts and new knowledge of child growth and development were beginning to emerge from psychiatric and child-guidance clinics, and from the child-research centers that had been established in various universities.

However, as the depression deepened in the early thirties, State and local health agencies found their funds for personnel and services severely reduced. In many States child-health programs built up under the Maternity and Infancy Act in the twenties were curtailed markedly or abandoned entirely.

By the fall of 1934, therefore, there was ample evidence of the need for renewal of grants to States for maternal and child-health programs, and for the establishment of Federal aid for the medical, hospital, and followup care of crippled children.

Landmarks for Children

Restoration and enlargement of the maternal and child-health program in that summer of 1935 meant that a new day for the health of mothers and children was born, especially for those in rural areas. New methods of work, new activities of many different kinds in maternity care, infant and preschool health programs, health programs for school children could now be stimulated through the special provision in the new Federal legislation calling for demonstrations in each State. A provision allowing part of the grant to be unmatched by State funds gave the States the opportunity to be imaginative as well as realistic in starting new training activities and new types of programs.

But this new development in maternal and child health was not the only landmark in the history of Federal-State programs for children reached on August 14, 1935. Three other programs for children came into being at the same time: those providing grants to the States for medical and related care of crippled children, for child-welfare services especially in rural areas, and for aid to dependent children wherever needed. This last was part of the income-maintenance provisions of the Social Security Act, which also included programs of assistance to the needy aged and the blind, and of social insurance against old age and unemployment. Subsequent provisions added survivors benefits on the death of the breadwinner to the old-age insurance program, and financial assistance for the disabled.

The grant-in-aid program of services to crippled children was the first Federal-State adventure in the realm of medical care. Through it State agencies have been able to establish or extend and improve State programs designed to locate crippled children and to provide them with hospital and clinic care, the services of doctors, surgeons, nurses, physical and occupational therapists, and medical social workers, and followup care in convalescent home, in the child's own home, in clinics or doctors' offices.

In the earliest days of the program there was injected the concept of treating the whole child rather than a paralyzed arm, a damaged heart, or a "case" of deafness or epilepsy. As a corollary there developed the concept of care by a team of professional workers, including doctor, nurse, social worker, therapist, psychologist, nutritionist, and educator.

As these new principles were put into practice to benefit handicapped children, their values spread to the work for children and mothers under the maternal and child-health service. Thus medical social work associated with the crippled children's programs began to have an influence in child-health clinics and in maternity services.

For that all-too-large group of our Nation's children, the "homeless, neglected, dependent, and those in danger of becoming delinquent," the Children's Bureau when asked in 1934 to frame proposals for legislation to improve the public provisions for children, brought forward two other major ideas. Both had grown out of studies and experience of the Bureau itself, of the State welfare agencies, and of many voluntary child-welfare organizations. From the days of the earliest societies for the prevention of cruelty to children in the 19th century to the nation-wide Federal relief program in the depression years of the early thirties there had developed increasingly clear concepts of the public responsibility for children lacking in appropriate care and protection.

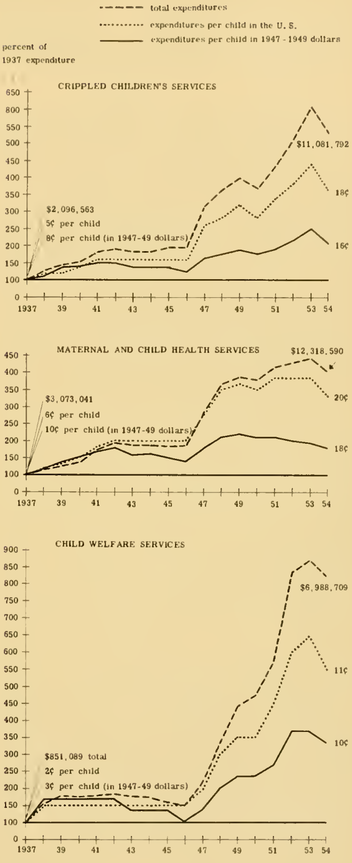
In the early decades of the 20th century, particularly in urban areas, some public as well as an increasing number of voluntary agencies had been developing practices and working out the principles on which State legislation for the care and protection of children could be based. The pendulum of professional opinion had swung away from institutions as the primary resource for homeless children. Foster-family placement gained ground rapidly in voluntary agencies and in the more advanced departments of public welfare. By the second and third decades the realization that children developed more normally when at home in the care of their own mothers led to enactment of State laws providing for "mothers' pensions" or "widows' aid" to families in which the normal breadwinner was dead or permanently absent. Encouraged by Children's Bureau studies that showed the value of such programs, an increasing number of States enacted such laws.

Despite this salutary development in State laws, the programs they authorized proved to be far from adequate, particularly with the coming and prolonged lingering of the great economic depression. This showed up sharply at a conference called in Washington in 1933 by the Children's Bureau to consider the emergency needs of dependent and neglected children. In only 15 States authorizing mothers' aid were there actual State appropriations; in others what aid there was came from local funds and was provided in only a few counties. Services to children needing other forms of protection were equally haphazard. In too many places such children were at the mercy of hit-or-miss decisions on the part of juvenile courts lacking probation or social-work staffs and were too often placed in institutions far from home and forgotten.

By 1934, then, the urge was strong for Federal grants to help all States extend financial aid and welfare services to children, particularly to the rural areas where little had previously been provided. The proposals made by the Children's Bureau for Federal grants to the States for child-welfare services and for aid to dependent children were modified in the process of legislation and eventually incorporated in the omnibus act as parts of the grant programs administered by the Children's Bureau and by the Social Security Board, respectively.

The close association in the Children's Bureau of the child-welfare and health programs has materially aided both. A basic concept of the Bureau that every child must be treated as a whole human being, growing, developing, reacting to adverse physical, social, or emotional conditions in various ways, has stimulated its health and welfare specialists to utilize and incorporate each other's knowledge, understanding, and skill in the planning and conduct of the programs for maternal and child health, for crippled children and for child welfare. Increasingly this same concept and similar interrelationships have developed in the States and localities. Increasingly local programs for the unmarried mother and her baby involve both maternal and child-health and child-welfare personnel and activities. Increasingly crippled children's agencies call upon child-welfare agencies when placement of children in foster families is necessary. Increasingly the nutritionists in

FEDERAL EXPENDITURES FOR TITLE V PROGRAMS



While considerably more Federal funds went into all three services in 1954 than in 1937, the expansion becomes less spectacular when expenditures are adjusted to a steady dollar value and to the rise in child population.

child-health programs give help to child-welfare workers with respect to diets for children in institutions. Increasingly there is joint action between health and welfare programs in utilizing mental-health resources for children and their parents and in developing more effective services to special groups of disadvantaged children such as migrants.

Cataclysmic Times

All the while these federally aided programs have been developing, cataclysmic events and miraculous discoveries have been affecting the chances of children for survival and for achieving a good life.

They began in the midst of a great depression marked by unprecedented unemployment and devastating drought—in the days when many teen-agers took to the road to relieve their parents of another mouth to feed, when many fathers despairing of their ability to support their wives and children walked out of their homes forever, when young people finishing school faced a bleak, jobless world.

Within a few years, however, the economic depression gave way to a period of unprecedented industrial activity—and war. Now teen-age boys left home not to roam the country in search of work but to kill or be killed on the battlefront. Others too young or rejected as unfit for military service dropped out of school to take jobs, attracted by the high wages of war industries. Young girls, many of them in their teens, left home too, to become camp followers, lured by the glamour of uniforms, the expectation of marriage, or a distorted idea of patriotism. Illegitimate births increased.

Child-labor laws cracked in State after State as the normal labor pool was drained dry and employers looked to adolescents to fill some of their needs. Women went to work in increasing numbers, leaving their small children with relatives, with older children, in day-care centers, or on their own. Others dragged their children from one overcrowded camp community to another in order to be with their husbands as long as possible. Thousands of nonmilitary families also tore up roots to move to already overcrowded industrial communities lacking in sufficient housing, sanitary facilities, or health, educational, recreational, or welfare services.

In those harassing days most health and welfare agencies, public and private, were caught on the horns of increasing demands for service and loss of personnel. Nevertheless, through the help of special Federal measures—such as the Lanham Act for the provision of community facilities, including day-care centers—the coordinated effort of national voluntary agencies by way of the USO, and the community-organization efforts of the Office of Civilian Defense, some necessary services were extended to the new or greatly overgrown communities around military installations or war industries. Because the section of the Social Security Act providing for child-welfare services mentions "areas of special needs" as well as rural areas, the focus of this program also could be turned to war-impact communities.

The good that came from the ill winds of war can mainly be found in the great technical achievements which have helped to revolutionize medical care and surgical and rehabilitative procedures. These have had a profound effect on services to crippled children. Also far-reaching in its aftereffects was the experience gained in providing maternity care to the wives of servicemen through the Emergency Maternity and Infant Care program. Established by Congress and administered by the Children's Bureau as part of its maternal and child-health program, this farflung project gave impetus to the improvement of obstetrical services in communities throughout the land, helped sharpen the skills and teamwork of the professional persons involved, and demonstrated the meaning of good prenatal and infant care to 1,250,000 young childbearing women.

The Climate Today

Ten years have passed since the first atomic blasts ended World War II and brought humanity face to face with its own power for self-extinction.

During this decade the country has been reaping the harvest of its wartime upheavals in high divorce rates—with their corollary of broken homes for children—and an almost steadily increasing incidence of violence and lawlessness among teen-agers, the babies and toddlers of those wartime days of family uprootings and separations. Moreover, many of the strains and upheavals of those war years have failed to disappear. New "defense communities" have sprung up around atomic installations, duplicating many of the living problems posed by the one-time war-impact communities. Post-adolescents are still leaving home and school for the Armed Forces. Young wives still follow their husbands from camp to camp and even across the seas. Employment among mothers of young children has remained high. Child labor has not entirely disappeared, especially in bowling alleys and on industrialized farms. Childbirth among unmarried

(Continued on page 160)

CHILD-HEALTH SERVICES SINCE 1935

EDWARD R. SCHLESINGER, M. D., M. P. H.

Associate Director of Medical Services New York State Department of Health

THE SOCIAL SECURITY ACT of 1935 established a new landmark in the development of health services for the mothers and children of the United States. One section especially, Title V, was of direct significance in the development and expansion of child-health services in the various States and Territories. This title authorized Federal grants to be made each year to the various States, through the Children's Bureau, to help them extend and improve their maternal and child-health and crippled children's services.

Although the Maternity and Infancy Act of 1921, commonly known as the Sheppard-Towner Act, had previously set a precedent for Federal grants for child-health purposes, the Social Security Act went beyond the provisions of the earlier legislation in several important respects. Services under the Sheppard-Towner Act had been confined to those relating to the maternity cycle and early childhood, whereas those under the Social Security Act raised the upper age level of eligibility to 21 years. Title V also authorized, for the first time, grants-in-aid for medical and related services for handicapped children.

Of most significance, however, was the fact that the grants under the new act were not conceived as temporary measures with a specific termination date. Many of the gains made with the support of Sheppard-Towner grants were lost in the early 1930's following the termination of the act in 1929. On the other hand, the size of the appropriations for both maternal and child-health and crippled children's services under the Social Security Act has been increased on several occasions since 1935.

The Federal grants have played a significant role in most States. In those with the lowest per capita incomes the grants established a means for financing child-health services. These States, generally with higher birth rates and more acute health problems, received proportionately greater Federal grants, often exceeding the proportion of taxes they paid into the Federal Government. The result was a much higher level of child-health services than they could otherwise have attained.

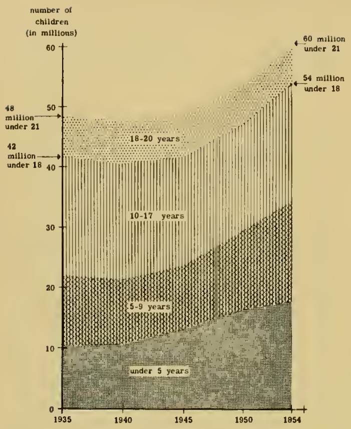
Even the more well-to-do States that had developed basic child-health services without Federal aid could point to tangible benefits from the grants. While they might have been on the short end of the stick in the exchange of Federal taxes and funds, the availability of Federal grants affected the further development of their child-health services. For them, the Federal funds often took on the semblance of an "extra," which State officials controlling the purse strings were more willing to use for experimental or demonstration programs or for special studies than they were in the case of direct State funds. The Children's Bureau's administrative decision to encourage the States to set aside a portion of the grants specifically for demonstration projects and broad training programs further paved the way for new departures in the child-health field.

An Era of Development

Passage of the Social Security Act came at the threshold of an era of unprecedented development bearing, directly or indirectly, on the health of mothers and children. During the next 20 years changes in the overriding concepts of health and of child rearing, the spectacular scientific advances in medicine and related fields, the broadening responsibilities of a number of professional disciplines in the health field, and changes on the social and legislative scenes all had significant impacts on the way services developed. Many of these changes were in turn affected by the direction in which child-health services were developing.

In the two decades since 1935 there has been increasing acceptance of health as a positive goal, and

RISE IN CHILD POPULATION



includes 17-20 year olds in the armed forces

Our population now includes 12 million more children than it did in 1935, and a much greater proportion of children than then in the 5–9 and under 5 years groups.

not simply the elimination of overt disease. This understanding was codified in the World Health Organization's definition of health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. During this same period there was a sharp swing away from rigid concepts of child rearing and toward a more permissive attitude that looked upon the infant and the child as a person whose emotional and physical needs should be met on an individual basis. The potential damage to the emerging personality from prolonged institutionalization, especially during infancy, was clearly established, with a resulting emphasis on placing young children in suitable foster families when they cannot be with their own parents. There has also been increasing realization of the possible emotional trauma resulting from hospitalization of young children, even in the absence of surgery, and a trend toward adequate preparation of children for the experience of hospitalization.

In 1935, the Nation was starting an upswing toward a prolonged period of higher living standards which accelerated rapidly after 1940 in spite of the dislocations of war and inflation. In the ensuing years the birth rate rose steadily and sharply until it reached and maintained a relatively high plateau during the past decade. The trend toward smaller families was reversed and the middle-class "ideal family" with two children gave way to a family of three, four, or more children. Even in the face of a high incidence of divorce and separation, family disruption on the whole was markedly reduced as a result of an even greater decrease of disability or death of one or both parents.

During these past 20 years new technical developments have come thick and fast in medical and related fields. First, the sulfa drugs, and later the antibiotics, accelerated the already rapid decline in mortality from infectious diseases during the puerperal period and childhood, and made possible the control of rheumatic fever and the kidney disease, acute nephritis. The availability of an improved vaccine has been a major factor in eliminating whooping cough as a public-health problem. Now the advent of an effective vaccine against poliomyelitis promises to accomplish similar results with infantile paralysis.

New developments in the use of blood and blood derivatives have had lifesaving applications in unexpected fields. A striking recent example has been the use of gamma globulin in infants and young children who suffer serious infections because of a low level of gamma globulin in their own blood. Advances in pre- and post-operative management and in surgical techniques have made surgery safe during the newborn period, and have made many previously hopeless conditions of the heart and blood vessels and other systems of the body amenable to surgical correction or alleviation. Lessons learned in physical medicine and rehabilitation during and after the second World War have been rapidly applied to the care of children as well as adults. Progress in electronics has made possible new developments in audiology for the testing and training of children with impaired hearing and for the development of hearing aids suitable in size and durability for children.

In some instances, solution of old problems has introduced new difficulties, only to be followed by solution of the new problem as a result of intensified research.

Two striking examples may be cited. After the relationship of Rh incompatibility to erythroblastosis fetalis, a generally fatal anemia of the newborn, was understood and applied, the improved survival rate following use of multiple transfusions appeared to be accompanied by an increase in the number of cases of kernicterus, a complication affecting the brain, with its frequent sequelae of mental deficiency and cerebral palsy. The development of exchange transfusions and of improved laboratory methods for determining proper indications for their use has reduced this problem to very low levels.

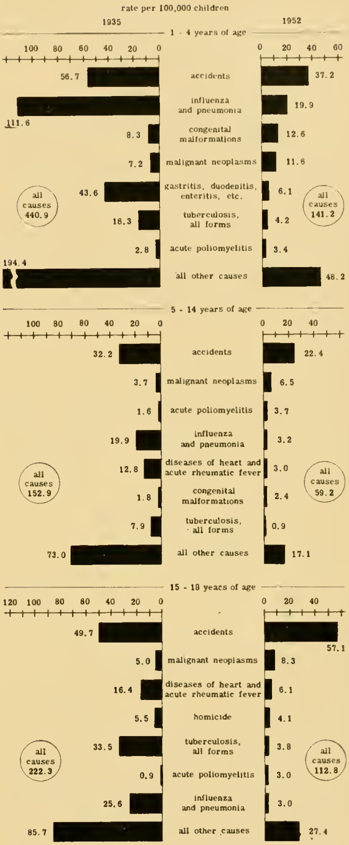
The rapidly mounting incidence of sight-destroying retrolental fibroplasia among premature infants caused some people to question the desirability of applying the expensive and time-consuming techniques which had been increasing the premature baby's chances of survival only to have a blind child as the outcome. The urgency of the problem stimulated research in many medical centers and finally led to an understanding of the role of excessive use of oxygen in producing the retinal changes and irreversible stages of retrolental fibroplasia. As a result, it is likely that new cases of blindness from this cause will become a rarity in the near future.

The Team Concept

The past two decades have also seen increasing acceptance and use of persons from many professional disciplines as essential members of the health team—social workers, nutritionists, health educators, and physical therapists, to name a few. Rather than displacing physicians and nurses from their traditional roles in the provision of health services, they have made new contributions as a result of their own specialized training and experience. These have strengthened the services of the long-established disciplines. A basic concept of care has developed. In essence, this implies the pooling of the specific contributions of each discipline, the joint consideration of the information obtained, and the common development and carrying out of a broad plan of treatment.

This team concept has been most highly developed in the management of children with various handicapping conditions, in which the treatment plan has included, along with physical rehabilitation, consideration of the child's emotional needs, adjustment of the child and his parents to the handicap, education, and, for older children, vocational testing, guidance, and training. Training of professional personnel has placed increasing stress on the team concept, especially in short-term training financed through

CHANGES IN CAUSES OF CHILD MORTALITY



Accidents continue to be a leading cause of death among children as deaths from acute diseases have dropped spectacularly. The figures for the 15-to-19-year-old group do not include deaths in the Armed Forces overseas.

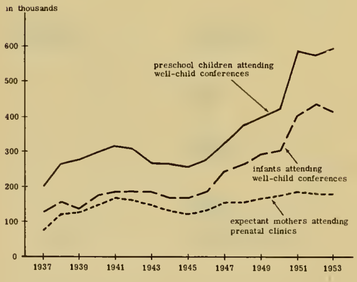
special grants from Title V funds. Teams from the different health disciplines in various combinations have been trained, for example, in the care of premature infants, in the management of children with rheumatic fever, and in the rehabilitation of orthopedically handicapped children.

For School-Age Children

Many changes have taken place in the provision of health services for children of school age. In the mid-1930's few voices had been raised to question the sterile program of regular health examinations of school children, with little attention to followup procedures to secure correction of adverse conditions found. The school physician was usually caught in the web of routine examinations, and little attempt was made to bring the family physician into the program. The emotional climate of the school and the management of the emotionally disturbed child were usually considered entirely apart from health services.

Today the routine cursory examination in the school is being replaced increasingly by more adequate, although possibly less frequent, medical examinations by the family physician or, when this is not possible, by the school physician. Screening tests for vision and hearing are being widely employed. Greater emphasis is being placed upon teacher observation of individual children and upon frequent conferences between teacher and nurse on suspected health problems. Often these conferences are a prelude to special examinations by the physician, so that the physician devotes his attention to the children most urgently in need of care. The school physician is increasingly being regarded as a consultant in all matters pertaining to health in the schools.

GROWTH IN MATERNAL AND CHILD-HEALTH SERVICES



Well-child conferences in the federally-aided maternal and child-health programs are now serving about three times as many infants and preschool children as in 1937.

True, these changes have occurred more in concept than in practice in all too many places. The longer history of school-health services and the weight of long-established practices have tended to retard progress more in this field than in other areas of child-health services. An added factor has been the divided and frequently unclear responsibilities of educational and health authorities in the administration of health services for school children. This problem must be resolved through joint planning and good will within the local communities.

Mothers and Infants

After a long period in which little headway was made in reducing maternal mortality, a dramatic change occurred in the mid-1930's when there began the steady, rapid decline in the maternal death rate which has led to the present low maternal mortality rates. Nevertheless, the rapidity of the decline has not led to complacency. There are probably more maternal-mortality conferences held under the auspices of medical groups and health departments, and more extensive maternal-health programs, than there were 15 or 20 years ago. The same techniques of investigation of maternal deaths, using the results of these investigations for professional education and to discover unmet needs in the community or State, have been applied to the still extremely important problem of intermediate and late fetal deaths and neonatal mortality.

Educational techniques aimed at better preparation for parenthood have also changed significantly. In 1935 classes for pregnant women, which had a tradition of well over a decade behind them, appeared to be on the wane. These classes placed a great deal of emphasis on preparation for home delivery and on the early diagnosis and care of serious complications of pregnancy. They were available mainly to low-income groups. In recent years a different type of class for expectant parents, often including fathers as well as mothers, has become prevalent.

Aimed at giving the participants a real understanding of pregnancy and childbearing, the modern classes have become important adjuncts to medical care, with participants usually being referred by their obstetricians. They convey important information on nutritional needs during pregnancy and on child care after birth. Most important, however, are the opportunities they provide expectant parents to express feelings and to ventilate anxieties in a group situation where they can see for themselves that their misapprehensions are common to many others. The resulting relief of anxiety about pregnancy and childbearing presumably helps establish a sounder base for later care of the children and for better family relationships.

Emphasis in child-health conferences has shifted from routine physical examinations, administration of immunizations, and advice on feeding to the mental-health aspects of child growth and development. The better child-health conferences provide ample opportunity for the mother to ask questions about the problems bothering her. The mother is kept informed of what to expect at each stage of her child's development, so that needless anxiety can be avoided and behavior problems prevented. In some instances the traditional functions of the child-health conference have become adjuncts to what is essentially an educational program, with child-study groups being formed by the parents of the children seen in the conferences.

Preventive Programs

In no field of child health has there been a more radical change than in that of dental health. In 1935 only secondary interest in children's dentistry was manifested by the dental profession. Even if all dental manpower could have been concentrated on the care of children's teeth, it would not have been able to clear up the backlog of dental caries and it probably would not have been able to keep up even with the increment of new caries. No preventive techniques were available which could be applied readily on a mass scale. There were few specific programs concerned with dental health, and there was little that such programs could offer. Such children's dental programs as did exist consisted largely of an endless treadmill of care for dental emergencies.

Today prevention of dental caries has come to the fore. Fluoridation of community water supplies, although still a subject of controversy similar to that aroused by pasteurization of milk and chlorination of water in the early days of these public-health procedures, is rapidly being applied across the Nation. By the spring of 1955, about 1,040 communities having a total population of 21 million were being served with fluoridated water. This is most impressive when one realizes that about one-quarter of the total population living in communities with water supplies lending themselves to fluoridation are already getting the benefits of this procedure. Children in these communities can look forward to having only one-third as many teeth affected by dental caries as have children in other localities and to the prospect of having simpler treatment to correct whatever dental caries develops.

For children living in areas where water fluoridation is not possible or practical, another preventive technique is available—the application of a sodium-fluoride solution to the teeth. A series of such applications at about 3-year intervals during childhood results in a reduction of about 40 percent in the number of teeth affected by dental caries. While such rapid strides as have occurred with water fluoridation cannot be expected in instances of topical application of fluorides, because of the number of trained dental personnel required, the use of this approach has spread rapidly.

Beyond this, courses in children's dentistry are now an accepted part of the curriculum of the dental student, and practicing dentists are showing a steadily increasing interest in children's dentistry. Many communities with fluoridated water supplies are now reaching the point where immediately available and interested dentists will be able to give adequate attention to the residual problem of dental caries.

With the sharp decline in the infectious diseases and other causes of mortality in infancy and childhood, death and disability following accidents have assumed relatively greater importance. Interest in the problem of childhood accidents has become widespread only in the past decade. Medical groups and voluntary health organizations, whose interests previously were focused exclusively on the diagnosis and treatment of disease and various disabilities, have promoted public-health education, legislation, and other measures designed to reduce the hazard of accidents to children. There has been growing appreciation of the dangers of leaving within children's reach common medicines such as aspirin as well as many household materials which are ordinarily not considered toxic. A recent development has been the organization of "poison centers" where persons who have taken toxic materials can receive emergency treatment and where information on the ingredients of various substances ingested by children can be provided to physicians and other persons on a moment's notice.

Paths for the Future

Much has been accomplished in the field of child health in the past 20 years. While we can be proud of our achievements, there is no room for complacency. Many needs must still be met. Meeting these needs will be a challenge to the ingenuity, energy, and devotion of persons in all fields bearing on the health of children. Future progress may be visualized as following three paths along which we must proceed simultaneously. These paths are: Research in the development of new techniques; the spread of available services to population groups not now reached; and increased depth of services to those already served.

Further research should be conducted in all fields of child health. In particular, intensified research is needed in what has been called the continuum of fetal wastage. The continuum starts with fetal and neonatal mortality, and extends through premature birth and through residual handicapping conditions, such as cerebral palsy, epilepsy, and mental deficiency, which are associated in varying degrees with disturbances of fetal development and delivery. The prevention of premature birth alone would cut the neonatal mortality rate in half and reduce to some extent the incidence of residual handicapping conditions. While much has been learned about the many factors which can produce congenital malformations in experimental animals, only a start has been made in applying this knowledge to the prevention of congenital malformations in man.

Mental health is another broad area for research. The possible relationship of controllable factors in emotional and social development to overt mental illness in later life still awaits clear demonstration. Similarly more needs to be known about the intrinsic factors of personality, the disturbances in intrafamilial relationships, and the adverse community pressures which lead to delinquent behavior in children and adolescents.

The second path to further progress in child health is the broader distribution of services to population groups now barely reached. Regular health supervision, public-health nursing, and other basic health services are still lacking in many rural areas and in some socially and economically underprivileged groups. These are the very groups in which a concentration of health problems exists and which are hardest to reach for child-health services. Children in migrant families suffer all the handicaps of an unstable environment, usually with inadequate and temporary housing, poorly prepared foods of low protective value, and insufficient, constantly interrupted formal education. Only recently has thought been given to the development of an organized health and educational program for these children which will follow them from crop to crop along the stream of migrant labor.

Finally, depth must be achieved in many child-health services now lacking the essential elements of complete programs. Too many demonstration programs have remained simply demonstrations of what could be accomplished on a broad scale if sufficient personnel and funds were available. Programs for handicapped children which lack consideration of the emotional needs of the child and his family inevitably fall short of their goal of fulfilling the child's rehabilitation potential. School health programs that still place emphasis upon sterile, cursory health inspections at frequent intervals cannot be expected to reduce the prevalence of so-called physical defects nor to educate children in the value of good medical care. Child-health conferences which consist mainly of immunizations and advice on feeding miss the chief values of parent education and guidance in promoting optimal emotional development of children. Any child-health program lacking in depth is poor economy in the long run.

In this brief discussion, it has been possible to present only some of the highlights in child-health developments over the past two decades. Clearly the momentum gathered over the years will result in further expansion and improvement of health services for mothers and children. What will be needed more than ever is periodic critical reappraisal of these services to be sure that outmoded procedures are not allowed to reduce their effectiveness and that proven new knowledge and techniques are applied as rapidly as possible.

TWENTY YEARS OF MATERNAL CARE

SAMUEL B. KIRKWOOD, M. D.

Commissioner, Massachusetts State Department of Public Health

IN THE 20 YEARS since the passage of the Social Security Act, a generation of Americans has grown to parenthood. Its children are being born into a different world. Twenty years ago 1 out of every 172 mothers died; today only 1 in 1,900 loses her life in childbirth. This dramatic saving of life is of tremendous importance, for of all tragedies perhaps the greatest is the loss of a mother's life. Yet it introduces other problems, for we can now turn to reduction of morbidity as a goal in itself. We can broaden our focus to see more in childbirth than the mere delivery of a living mother and a healthy child. Now that this basic essential can be assured, we can dare to look at our methods to find out whether some elements of value are missing—or even whether some have been lost in the process. Perhaps we may even accept maternal care in its broadest sense as part of every phase of a woman's life. In any event, at this 20-year mark a pause for reflection should be worth while.

In reviewing the developments of the past 20 years it is rather astonishing to realize that the entire history of any concerted efforts toward providing maternal care barely antedates the score of years preceding them. The first prenatal clinics were established in this country shortly after the beginning of the century. The development of modern maternal care has taken place in the United States within the last 50 years.

The first step was bold and brilliant. For centuries maternal care had begun with labor pains. The idea of preventing maternal diseases and obstetrical difficulties by anticipating them broke widely with tradition and made possible the future of maternal care. The prenatal clinic became a practical demonstration of the elimination of disease through organized means for detecting its earliest signs and symptoms. Gradually another fundamental principle was established—that obstetrical difficulties could be controlled through building a sound physique by measures of general hygiene. It seemed logical that maternal mortality could be conquered by a wide expansion of these clinics.

Great progress was made, but the results fell short of hopes. Apparently only a partial answer had been found.

As time went on closer inspection of mortality statistics brought out an important fact. Although the overall death rates had been reduced, the relative ratios of the three major causes—toxemia; sepsis; hemorrhage, trauma, and shock—remained essentially the same. Any improvement, therefore, reflected advances against all the hazards of pregnancy and not against any one alone.

Broadening Concepts

Good prenatal care availed little if accouchement was delegated to poorly trained practitioners with poor facilities. Sepsis in the puerperium resulting from inept delivery could undo all that good technique had accomplished up to that point. Realization of this profoundly affected all future programs, for it brought realization that advance must be made along a broad front. To be sure, salients here and there could be pushed out, but the line eventually had to be straightened.

This concept at first seemed to supply all that was lacking to reach the ultimate goal—that no mother or child should die or suffer harm in childbearing. But another element was even then entering the picture—consideration of emotional stress and strain as factors of importance in practical programs designed to reduce maternal mortality. At the same time, under the stimulus of the great pioneer social workers, more and more attention was being directed to the effects of social and economic conditions upon people in general and on the family—and hence the pregnant woman—as the basic unit of our society.

The credit for this broadened view of the pregnant woman goes to no one group in particular. The physician, the social worker, the medical schools, the nurse, the midwife, governmental agencies, and the people—parents and others—all had their parts.

By the time of the Social Security Act of 1935 the general outline of the years ahead was established. Like the Sheppard-Towner Act, which preceded it in making provision for maternity care, this legislation accepted the principle of local initiative and responsibility with financial and professional help from the State and Federal governments. Thus there could be three-way support in moving forward.

Reduction in Mortality

If 1935 rates prevailed in the United States today 24,000 mothers would die this year. Instead only about 2,000 will lose their lives. For the sake of the future this accomplishment deserves analysis.

The same major causes of maternal death have kept the lead throughout these 20 years. But all have been drastically reduced and changed, as the following table shows:

MATERNAL MORTALITY BY CAUSE, UNITED STATES 1935 AND 1952

	1935		1952	
	Percent of total deaths	Rate per 10,000 live births	Percent of total deaths	Rate per 10,000 live births
Sepsis	41	24.0	19	1.3
Toxemia	22	12.7	35	2.3
Hemorrhage Trauma Shock	31	18.2	30	2.0
Others	6	3.3	16	1.1
Total	100	58.2	100	6.8

The reduction in deaths from toxemia has resulted from generally improved prenatal care, for 20 years of research has not produced a specific cure for this disease of pregnancy. The greatest single factor in its control is constant watchfulness—continuous observation, examination, and hygiene teaching. This involves many tools, from the simplest readings of blood pressure, weight, and albuminuria, to complex socio-psychological studies. One of the most useful—since it is controllable—is optimal nutrition development through diet guidance, with motivation of the mother by a physician or a nutritionist. This has proved valuable both as a preventive and a therapeutic measure.

Of all the major causes of maternal mortality sepsis has yielded most to frontal attack by the sulfonamids and the antibiotics. The development of these antibacterial agents is the one most dramatic event of the last 20 years and one of the most dramatic in medical history.

Two important elements of care brought about the drop in deaths from hemorrhage, trauma, and shock. First, a tool, as valuable as the antibiotics in control of sepsis, was greatly improved—transfusion. Blood transfusion, of course, was used long before 1935, but in the past 20 years the techniques it involves have been improved to such a degree that it is now available almost wherever babies are born. Secondly, today's obstetrician, general practitioner, nurse, and midwife all are better trained. They possess knowledge, technical proficiencies, and judgment that a generation ago were the prerogatives of their teachers alone.

In 1935 the general category of "other causes of death" contributed only 10 percent. Today this percentage has risen to 16—due to the great decreases in the three major causes. This miscellaneous group now demands the attention it has been denied in the past. Fortunately, various specialists have become increasingly interested in these problems.

It would be unfair to judge the past 20 years alone on the basis of mortality, for they also have included other great steps forward.

Morbidity has fallen. There has been a vast improvement in the condition in which the postpartum mother now is returned to her nonpregnant state. An increasing realization of the impact of disability in the mother upon the entire family has brought about an appreciation of the close relation between the physical and social elements in maternal care.

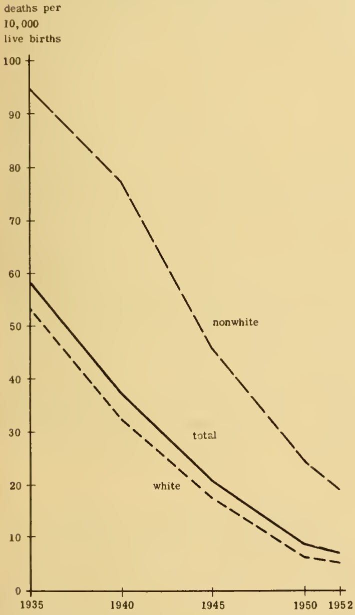
Efforts to improve the nutritional status of pregnant women through diet control have been an important factor in the reduction of morbidity as well as in the management of toxemia. As standards have been established and studies conducted to test their application, practical programs for nutritional betterment have become recognized as a vital part of general pregnancy care.

Changing Methods

The past two decades were also years of great change in anesthesia and analgesia. All forms of inhalation agents were tried, and spinal and local techniques were developed. Although certain clinics formed a preference for one type as a routine, most interpreted their experience otherwise, using each type according to its distinctive value. Studies also brought out the important fact that obstetrical anesthesia had definite problems and peculiarities of its own and so could not be considered just another phase of general surgical anesthesia. One of the major differences lay in the necessity of considering the effect of maternal anesthesia on the fetus. Inevitably a group of specialists arose who devoted their full time to obstetrical anesthesia with great benefit to the safety of both mother and child.

The year 1935 was very close to the first major revaluation of the earlier "twilight sleep." Many efforts were made to find analgesic drugs that would relieve the pain of labor without adverse effect upon the child. The aim was a labor if not without pain at least without memory of pain. Many drugs and combinations were tried with varying success, all falling short of the ideal.

DROP IN MATERNAL MORTALITY 1935–52



Deaths of mothers in child bearing have dropped rapidly since 1935, but the death rate among nonwhite mothers is still more than twice as high as among white mothers.

Paradoxically, these same years also brought almost violent reaction to the search for a perfect analgesic. The proponents of "natural childbirth" set a goal which was the exact opposite—a complete awareness of the experience of childbirth. Unfortunately, this became equated with "childbirth without fear" and "childbirth without pain," thus focusing on the very element to be eliminated. Nevertheless, these pioneers served womenkind well, for they showed that neither analgesia nor anesthesia were necessary elements of childbirth and, therefore, could be eliminated if desirable. The next 20 years will see this method assume its proper place in maternal care.

In close association with "natural childbirth" has come a move toward "rooming-in" or keeping the baby in the same room or near the mother. The two systems go together rather well but are not necessarily linked. They have also paralleled a gradually revived interest in breast feeding. Many clinics have established elaborate facilities and teaching routines for rooming-in. However, it has become apparent that the spirit that motivates the hospital staff is more important than either physical setup or schedules.

All these developments have been part of a steady march toward the concept that maternal care should support the normal physiology of pregnancy and reduce interference to a minimum.

Another major development in the last 20 years has been a steady increase of hospital deliveries. While in 1935 only 37 percent of all deliveries in this country occurred in hospitals, the proportion had risen to 90 percent by 1951. Much discussion has occurred over the question of whether this is for the best. At least it has coincided with the reduction of maternal mortality to the lowest figure on record.

Changes have also taken place in academic obstetrics. Surprisingly little actually was known 20 years ago of the physiology of reproduction, the profound physiochemical reactions that take place during pregnancy. But the ensuing years have been an era of greatly expanding research, bringing to the study of pregnancy some of the best researchers in all fields of medicine. As a result, the pregnant woman has emerged in a new light, as a totally different person—not as one whose nonpregnant state has been interrupted by the addition of pregnancy, but as one who is now in the pregnancy phase of her life. The obstetricians have themselves worked in these new areas. They have also found new resources in the increasing number of related professions and have thus been able to make wider distribution of their own talents. The differences between urban and rural service have constantly lessened.

During this period the obstetrician and the pediatrician have gradually drawn closer together so that the division between maternal care and infant care tended to break down. At the same time infant mortality has dropped. But a residuum has remained which has failed to respond, at least by comparison. This is the perinatal group of deaths—the stillbirths and the neonatal deaths of infants under a week old. Clearly the conditions underlying this loss of life are obstetrical, and, if the pediatrician is to help, his influence must be felt long before delivery; or, in reverse, the obstetrician's responsibility must carry beyond birth.

Socioeconomic Influences

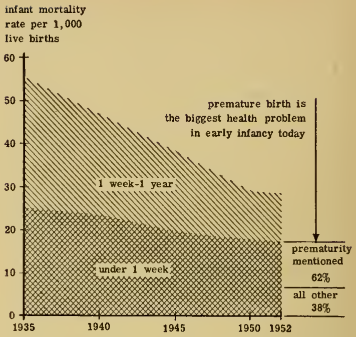
The most significant development in maternal care began to take shape toward the end of this 20-year period. It came from a series of questions forced to the surface by the growth of pregnancy care.

Can continued improvement in the technical means of care eliminate the residue of maternal mortality? Or are there other indirect, perhaps more subtle influences with which we must reckon? Is it enough to deliver a healthy unharmed baby from a healthy uninjured woman? Or are there other responsibilities the physician must assume as a part of good maternal care? The answers to these two groups of questions lay in the facts of modern life.

Over the years it has become clear that many social, economic, and psychological conditions engendered by society today are reflected in the well-being of mothers and children and even in seemingly specific causes of death.

Many of the most difficult problems of maternity care in this country in recent years have had their roots in the changed status of the family and more particularly of the woman. In earlier times almost every woman had home building as her career, but in recent years social and economic forces have both led and forced many women into a new world apart from the home, a world in which they must compete in traditionally masculine work yet retain their own attitudes. Since these forces have changed neither the physiology nor the psychology of women, the mother remains still the one best agent for infant care. By diverting her attention from this role these forces strike directly at the heart of the family.

REDUCTION IN INFANT MORTALITY



While the infant mortality rate has dropped sharply since 1935, deaths among babies in their first week of life have not gone down to any appreciable extent.

That the effects of socio-economic factors in childbearing are not just theoretical was demonstrated by the recent work of Baird in Aberdeen.[1] He found that he could divide women in his study on the basis of height as a variant both to social status and nutritional state. Women over 150 centimeters tall showed a more "female" type of pelvis and had fewer difficult deliveries, while those under this height tended toward the male or android structure. Other studies in England and Wales, Scotland, Sweden, and Holland have demonstrated a relationship between the incidence of stillbirth, premature birth, and neonatal mortality, and the socioeconomic classification of the family.

The problem of the unmarried mother also stems deeply from sources within the economic and social structure. The social and economic factors associated with illegitimate birth are almost always unfavorable.

Emotional Factors

The importance of psychological pressures have also been increasingly recognized. Many of the economic forces have, in fact, produced their effects through emotional strain. The economy of the marginal income may be sufficient to provide an adequate diet, but the fear and worry of the constant struggle to make it do so may be devastating. The mental anguish of the mother who would choose to stay home but is forced into employment by sheer economic necessity is very real.

There has also been much emotional maladjustment of mothers to their families and to their place in the community that does not derive from economic conditions. Modern education often trains women for work outside the family rather than for a position as the center of the household. When a woman's training conflicts with her basic urge toward motherhood emotional stress appears.

In these days of "mechanization" of so many of the processes of our daily lives it has been natural that similar methods should have been tried in maternal and child care. The growth of great clinics has brought the best of medical service to large numbers of women who otherwise would not receive it. However, this approach may have eliminated a vital and satisfying relationship that existed when the child was born literally into the family and took his place as a member of the family group from the very beginning of his life. In that instance the roles of father, mother and children were clear cut. Natural, fundamental, psychological impulses were fulfilled. With the loss of this more simple environment other advantages also may have been lost.

Many questions have been asked in recent years about the relative values of hospital and home delivery. Why do mothers of one country of the world voluntarily choose hospital delivery, while those of another turn more often to confinement in their own homes? How is the family integrity maintained during the absence of its central member? Should the wife be denied the support of her husband in the climax of *their* pregnancy? How can the new baby be introduced into the home from the hospital? How can the mother's worry over conditions at home during her absence be alleviated? How can the very essential child-mother relationship be developed in an institution? How can the mother be given a sense of psychological security when her care is divided among a series of individual midwives, nurses, and doctors? How can the sense of security that stems from familiar surroundings be substituted in the strange "aseptic" atmosphere of a hospital? How can the mother's fear of the dangers of complications be allayed in a home delivery away from the hospital's equipment? These questions go deeper even than questions of blood pressure, weight, and Wassermann reaction.

Other questions have also been asked, stemming from the hopes and fears that arise in the minds of a young couple when the fact of pregnancy first becomes known. How is a relationship with an outside person or agency established in as intimate a matter as pregnancy? How can these external aids be introduced into the family without being an intrusion? How can the confidence—indeed, the faith—of the mother be secured by relative strangers in this important period? How can a professional person give support to a mother-to-be who suddenly realizes that her whole life is now to be changed? Such questions have led to increased attention to the slow psychological preparation of the wife, the husband, and their other children for the baby's arrival.

These emotional stresses may be working for the good of the mother and her child, but they can also be threatening in their possible influence. Guiding her safely through them takes sensitivity and sagacity on the part of those dealing with her.

Today's Advantages

Such sociological, economic, and psychological influences already have affected profoundly the maternal-care programs of our country. In fact, the American woman herself has changed for the better under their pressures to a very great degree. Her physique unquestionably has improved as standards of living have risen in the past 20 years. Better living conditions and better nutrition have certainly played their parts in equipping her better for childbearing. This generation of mothers is the first to have gone through the teens without facing the hazards of disease which threatened their mothers and grandmothers—chlorosis, typhoid, and tuberculosis, for example. Emotionally too, the American woman has changed. She has a greater knowledge of her own physiology and of what factors actually do influence health and prevent disease. Childbirth is no longer a mysterious phenomenon. She can look upon it in an intelligent, objective way.

The mother of the present also has the advantage of a better environment. To be sure, it is a complex environment filled with frustrations, stresses, strains, and pressures, but at least it is one in which these factors are recognized. To reduce them as much as possible is beginning to be accepted as a responsibility of maternal care.

The physical environment in the hospital has changed for the better. The emergency maternity and infant care program of World War II did a great deal to improve hospital procedures and facilities. Recently more adequate obstetrical facilities

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have been provided under the Hill-Burton Act, while the development of hospital licensing authorities by many States has also added to the improvement of hospital care for maternity patients.

These improvements have come none too soon for the increasing birth rate has placed a tremendous load on hospital facilities. A hospital built for 2,500 deliveries a year ago is now caring for more than 5,000 maternity patients each year. Although the shorter hospital stay tends to eliminate overcrowding to some degree, the problem still remains.

More important than the physical facilities available in today's environment are the professional people surrounding the mother who are trained to serve her throughout this period of her life.

First, of course, is the physician, who must take the ultimate responsibility for the care that the mother receives. He is far better equipped for this task than was his own professional father 20 years ago. Although the general practitioner remains the backbone of maternal care and services, more specialists are now available to him. There is also better distribution of well-trained men throughout the country. The physician of today also recognizes the help that he may obtain from workers in the ancillary medical services. He is beginning to appreciate the fact that each of these workers has a unique contribution to make to the mother and to her family. True, it has taken time to establish the team concept. The realm of maternal care has so long been a relatively personal patient-physician relationship that the idea of several people being involved has been hard to accept. It has taken time also for the other team members to gain their professional wings in this particular field and to find their proper relations to one another.

The nurse remains as the doctor's first helper but with a much wider application of her skills. She is a member of a group who must somehow provide continuous care though her time is divided among office, hospital, and home. If she is in addition a midwife, as many nurses are, she has even further responsibilities.

Social workers, nutritionists, mental hygienists, and health educators are more recent additions to the medical team and have created a demand for their services far beyond the number of trained workers they can furnish.

The pediatrician's role as a specialist in this team has already been discussed.

The final "member" of the team is actually the community or the State. Because so many of these valuable ancillary services are difficult to provide, the State inevitably must come into the picture in helping to furnish them. This is particularly necessary since the general practitioner, who in this country is the principal accoucheur, is overworked and in need of help. It is the community's responsibility to see to the provision of consultations for him in all necessary areas.

Nevertheless, in spite of all that the State can provide most of the deliveries will continue to take place with a minimum of personnel. While no one man could be expert in all of the areas of specialty required, the practitioner can and must recognize the areas that need to be covered and to the best of his ability cover them or seek help elsewhere.

Lest one become complacent about the accomplishments of the past 20 years, two very sobering facts must be underscored which stand clearly between the present and the future in maternal care. First, it is now possible to add as part of maternal care services which specifically support the social, emotional, and psychological values lying at the heart of the family. Second, low though our maternity mortality is, 50 to 75 percent of all maternal deaths that occur could still be prevented if the full benefit of modern medical knowledge were available to all maternity patients. Implicit in these two facts are responsibilities.

The future must seek answers to two major questions: How can the utmost of technical proficiency be secured and maintained? How can the emotional and social values of the family be preserved? These must be answered within the structure of a social and economic world that is growing more and more complex. Those who would attempt answers must state them not only in terms of physical conditions, but also, as Sir James Spence would put it, in terms of "courage, gaiety, self-confidence, and sympathy." Only through the mother, the father, and the family can this expression take place. Those who are dedicated to help must be the first to appreciate this. Their task, therefore, becomes doubly difficult for the future. They must continue in their efforts to save lives—for no mother should die—but they must also play a big part in making better living.

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[1] Baird, Dugald: Preventive medicine in obstetrics. New England Journal of Medicine, 246:561–568, April 10, 1952.

SERVICES TO CRIPPLED CHILDREN, 1935-55

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THE FOLLOWING REVIEW of developments in the care of handicapped children during the past 20 years has been compiled from comments of directors of State crippled children's programs in various parts of the country. A request to all State directors for a "few paragraphs" on what they would like to see emphasized in an article brought 25 replies.

These comments were impressive in revealing the quality of the directors' ideas, their obvious concern for extension and improvement of total care of handicapped children, and an indication of nationwide ferment toward better integration of services. The feeling that crippled children's programs are still in a stage of dynamic growth came through very strongly. Undoubtedly the programs are riddled with unsolved problems and glaring omissions. Nevertheless the communications from the States provoke a thrill of pride at the vigor and vision with which these are being attacked.

Many of the letters pointed out that some State crippled children's programs preceded the passage of the Social Security Act, in a few instances by many years. All, however, acknowledged that the act gave "tremendous impetus to the broader development of services for children, particularly in rural areas," through its three-way partnership arrangement involving local, State, and Federal governments.

Twenty years ago the purpose of the program was set forth in the Social Security Act, title V, part 2, section 511, as follows:

". . . enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress) as far as practicable under the conditions in such State, services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling . . ."

While the Federal Government has increased its share of the expenditures for crippled children's services threefold since 1940, when it spent $3,700,000 on the program, State and local governments have in the same period increased their contributions sixfold—from $5,600,000 in 1940 to $29,800,000 in 1954. However, approximately 40 percent of the State and local share in 1954 was raised and spent in only four States. Some States, with comparatively low incomes, appropriate very little more than the amount necessary to match the Federal dollars, while one or two are not putting up enough to draw the full amount of Federal aid due them.

Basic Philosophy

Any program of medical services for crippled children needs guideposts to point direction and goals. These vary somewhat from State to State but on the whole derive from an underlying philosophy which may be stated in four basic principles:

1. The program has a humanitarian basis growing out of a normal concern for the well-being and happiness of children. This is widely recognized and accepted. Less well understood is the tremendous economic saving to the State in dollars and cents associated with transformation of potentially lifelong handicapped, dependent, unemployed persons to useful citizens. Increase in manpower resources and the consequent gain in national security is an additional consideration.

2. Primary emphasis should be directed toward application of the increasing numbers of preventive

measures which medical science is providing. Programs for crippled children should never be allowed to become mere salvage operations to patch up disabilities which need never have occurred.

3. Every service needed for the total medical care and rehabilitation of the crippled child should be employed. All available private resources should be utilized and the balance financed from public funds. Continuing effort should be made to encourage individual initiative and the assumption by parents, within their ability, of responsibility for the care of their handicapped child.

4. The effectiveness of a State crippled children's program depends upon the degree to which its activities are correlated and integrated with the medical and allied professional groups, medical schools, hospitals, voluntary health agencies, and various social and educational agencies in the State and local community. A program is not and cannot be made a self-contained unit.

In applying these principles it must be remembered, as Eliot[1] has recently reminded us, "that physically handicapped children are particularly exposed to discrimination, isolation, and rejection by the community and even sometimes by their own families." Said Dr. Eliot:

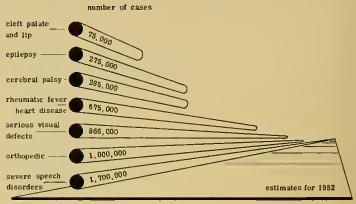
"We know only too well that any child who is rejected or who feels himself deserted by his family will find the road to a healthy personality a most difficult one.

"Handicapped children then, even more perhaps than normal children, need the bulwark of family trust, affection, acceptance, and support if they are to avoid overt aggressive behavior, even delinquency, on the one hand, or the building of walls of defense by retreat within themselves on the other. This places a great burden upon all of us who have a part in guiding the future development of this program to *continue to look at our procedures and practices.* We must make sure that everything is being done that can be done to bring complete health to the children under care."

Coverage and Priorities

The most consistent trend nationally, as revealed in the letters from the State directors, has been the broadening of the definition of a crippling condition. During the early years of the program most States concentrated on providing services for orthopedic handicaps in conformity with the then current definition of the term "crippled." Disabilities amenable to plastic surgery such as cleft lip and palate were soon added. About 1941 several States, stimulated by Federal funds for "special projects," began to set up demonstration programs for children with rheumatic fever, rheumatic heart disease, and hearing impairment.

INCIDENCE OF SOME PHYSICAL HANDICAPS AMONG CHILDREN



Then cerebral palsy, previously included under orthopedic conditions, began to receive special attention in several States, which developed projects designed to further integrate medical and educational services by providing physical, occupational, and speech therapy and medical, psychological, and social supervision simultaneously with the education of the child.

Recently this integrating trend has accelerated and has been extended to a host of new handicapping conditions. In addition to those already mentioned conditions receiving special attention in State programs today are sight conservation as well as eye disorders amenable to surgery, speech disabilities of all types with the point of reference being "communicative dysfunction," congenital heart disease, epilepsy, nephrosis and nephritis, diabetes, asthma, severe orthodontic defects, and even the clinical aspects of specific reading disability.

These trends have been accompanied by concern over what one State director described as "the emotional factors involved in not only the impact of sudden disability and the disturbance of normal growth and development of the personality by congenital or early disability, but also the physical expression of emotional disturbances which require careful and complete evaluation." As an example of the latter he cited efforts toward the detection of functionally deaf or hard-of-hearing children.

Practically all of the responding State directors stressed the insufficiency of appropriations to meet the needs of at least some types of conditions. One program director pointed out that "not only has the cost of medical care per individual unit gone up tremendously within the past decade but furthermore the amount of medical care per person has also increased so that at the present time we are faced with a serious problem in meeting the financial cost for such improved care."

As a matter of fact, funds, personnel, and facilities for crippled children's services will probably always be limited in relation to actual need. This means that program directors, staffs, and advisory groups must think about spending available funds in a way to achieve the greatest benefit for the largest number of children at the least cost. In developing a balanced array of services, increasing attention is being given to priorities of emphasis stemming from sound public-health criteria rather than from sentiment. Basic criteria are: [2]

1. The number of children affected.
2. The severity or potential severity of the handicap.
3. The amenability of the handicap to medical therapy and preventive measures.
4. The likelihood of the child's becoming, if untreated, dependent, unemployable, and a permanent public responsibility.
5. The unfavorable effect of the handicap on the emotional, economic, and social status of the child and his family.
6. The extent of interference with satisfactory progress in school and future employment.
7. The cost per child to secure maximum benefit.
8. The progressiveness of the condition.
9. The availability of special personnel and facilities for treatment.

Standards and Distribution

Undoubtedly the most significant and enduring contribution of the State crippled children's programs has been the way they have carried the torch for high standards of medical care.

For the past two decades the persistent insistence on a high quality of care has been notable. It has paid off large dividends in terms of qualifications of professional personnel; high standards of facilities used; and organization of services so that children can be moved freely from rural areas to medical centers and back, from hospitals to long-term institutions, from hospitals to their homes with all of the needed resources and services available to them at each point.

The concept of total care provided in orderly continuity and directed to the whole child within the family unit is a brilliant achievement. The development of administrative operations with sufficient flexibility to carry it out is an equally important accomplishment.

A large part of the credit for these achievements should go to the orthopedic statesmen who had the vision and drive to insist on high standards back in 1935 and before. History will also surely chalk up several points on this score for the Federal Children's Bureau. As one State director put it, "Children's Bureau consultative service to the States has promoted establishment and maintenance of standards of medical care and has indoctrinated State staffs in new and broader concepts of care of children."

In this connection another significant result has been the tendency of private agencies to adopt the standards of care set by State agencies for both treatment facilities and personnel.

Of first importance in the elevation of standards and in the development of new programs has been the use of a portion of the Federal grants for providing opportunities for special training. Federal money has been used to support courses in pediatric nursing, cleft-palate surgery, audiology, the care and treatment of epileptic or rheumatic-fever patients, and various aspects of physical therapy, as well as to provide for medical social work field practice in agencies for crippled children.

One of the outstanding characteristics of medical practice in the past 50 years has been the trend towards specialization and urbanization with a consequent maldistribution of personnel and facilities, especially for complex diagnostic problems and long-term care. Medical specialists, diagnostic facilities, laboratories, and the other impedimenta of modern medicine have congregated in large metropolitan centers resulting in a geographic roadblock for the crippled child who lives in a rural section.

"One very certain value of crippled children's services has been their ability to reach children in rural areas who otherwise would be neglected," was but one of a number of such comments from the program directors. Nevertheless, the inherent difficulties imposed by long distances in providing complete and continuous care continue to be formidable. Said one comment from the West:

"Many of our children are 400 miles away from the closest center. If your children in Baltimore had to travel halfway to Chicago for treatment, you would get some idea of what we are up against. The problem of followup from the center is difficult and we are finding that most of our followup must be done through public-health nurses who have received in-service training in this field. The problem of distance in the Western States has never been satisfactorily solved. The travel costs for the State board of health personnel are very large and the time consumed cuts down on the efficiency. Since we have no medical school in the State, we use several out-of-State for postgraduate training."

Some States are attacking this problem through the establishment of regional and district offices.

Interprofessional Approach

Nearly all of the communications from the States produced emphatic evidence that the team approach is perhaps the dominant trend at the moment in organization of services.

State after State described plans for bringing together a group of specialists to work as a team in a crippled children's clinic or center. More and more we find a pattern in which a medical specialist, such as an orthopedist, and the pediatrician, medical social worker, public-health nurse, and physical therapist work together to evaluate the problem and formulate a plan of continuous care. In many instances a special educator, either in person or through appropriate communication, becomes a member of the team. For older children the vocational counselor from the State Vocational Rehabilitation Service joins in the task of making a long-range plan.

The postclinic conference is rapidly becoming a popular and effective way of reaching a deeper understanding of all the problems imposed by the disability and helping parents to plan to use all community resources in their solution.

As community mental-health organizations and child-guidance clinics increase in number, a close relationship is being established with them by crippled children's centers and clinics. Thus they can bring the skills of a team of psychiatrist, clinical psychologist, and psychiatric social worker to bear on the problems of those crippled children in whom difficulty in accepting needed treatment or excessive emotional disturbance compounds the underlying problem of physical handicap.

In the case of the subtle and complex problems associated with hearing impairment and speech disorders, the ball is now usually being carried by a skilled and smoothly functioning trio of otolaryngologist, clinical audiologist, and speech therapist, who work closely with the pediatrician, the public health nurse, and the medical social worker.

The field of sight conservation still seems to be lagging behind this trend. Better teamwork needs to be worked out between opthalmologist and optometrist before the great bulk of the difficulties can be overcome, especially in rural areas.

Many of the directors' letters expressed great enthusiasm for the new approach to total care of infants with cleft lip and palate. Nearly half the program directors referred to the development of an integrated cleft-palate clinic. One rather detailed comment illustrates how far interprofessional collaboration has advanced:

"The speech pathologist begins counseling the parents of the cleft lip and/or palate child at the time of the first application to the Crippled Children's Division. He sees the parents on the same day that the child is examined by the plastic surgeon, which is usually the day before hospitalization for the primary closure, with the emphasis usually being on the problem of the child's future speech. Contact is then made by the Division's medical social consultant and the on-going care begins.

"At the age of about 4 years, the child is sent to the university dental school for dental X-rays, head plates, and wrist films, at which time molds of the mouth are also made. At this time the child is also seen by a pedodontist. By then the speech pathologist has made his evaluation, the medical social consultant has followed the case closely, and the plastic surgeon has seen the child yearly to suggest any operative procedures that may improve the cosmetic effect.

"After the age of 5 years the child, accompanied by his parents, is examined by the plastic surgeon, speech pathologist, representatives of the dental school who had performed the original examination, plus an orthodontist and prosthodontist from private practice. A pediatric examination is given and after each specialist has had an opportunity to study the patient's history, examine the patient, and review the dental films and molds, a case conference is held at which time the orthodontist, prosthodontist, plastic surgeon, pediatrician, nursing consultant, and social worker discuss with the speech pathologist any method at the disposal of the respective specialist which may improve the child's speech. There is a free flow of ideas among all of the specialists to determine what surgery, orthodontia, or prosthodontia may be necessary to give a good cosmetic effect and normal alinement of the teeth, as well as any type of device which will improve the child's speech.

"For the next 15 years the parents are instructed from time to time by the medical social worker on how best to coordinate all the services. The nursing consultant sends the composite data to the public-health nurse in the child's own community. She then coordinates the followup care and urges the family to get all necessary work done so that the orthodontist and prosthodontist may properly carry out their function."

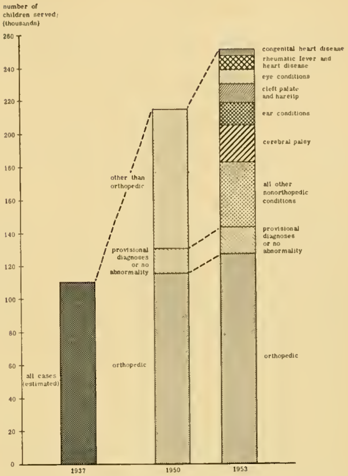
Accent on Prevention

The people who wrote Title V of the Social Security Act back in 1935 had the vision to see the great importance of applying the principle that an ounce of prevention is worth a pound of cure. This idea is incorporated in this section of the act by the wording "or who are suffering from conditions which lead to crippling."

In the early years of the program relatively little attention was paid to preventive possibilities possibly because of the preoccupation with taking care of the backlog of severely handicapped children. Even in 1955 much remains to be done in putting into day-by-day practice the close relationship which should exist between maternity, infant, and preschool, and school health programs on the one hand and crippled children's programs on the other.

In recent years, much more attention has been focused on the preventive aspects of crippling, partly because of stimulation from the Children's Bureau through a variety of "special projects." The concept of different levels of prevention is now widely accepted. "Primary" prevention for example would be pasteurization of milk to reduce the possibility of bone tuberculosis; smallpox, diphtheria, and other active immunizations to prevent various disabilities; the provision of cod-liver oil to avoid rickets; and a host of other procedures. "Secondary" prevention refers to the planned and systematic application of early case-finding techniques, prompt and definitive diagnosis, and arrangement for treatment and meticulous followup so that the "condition which leads to crippling" is taken care of before handicap results or becomes severe. Early diagnosis and care of rheumatic heart disease and hearing impairment are typical examples of this approach. Such preventive efforts require careful organization of services, constant effort to follow through each case, and close and cordial collaboration between the crippled children's program and the maternal and child-health and school health programs, voluntary health services, medical schools and teaching hospitals, and other community services.

GROWTH OF SERVICES TO CRIPPLED CHILDREN



The expansion of federally-aided services to crippled children has been largely for children with other than orthopedic diagnoses. The great majority of those served in 1937 had orthopedic and plastic conditions.

Perhaps the greatest challenge facing crippled children's programs at this time is subtle, sustained, and complex cooperative community action needed to realize fully the goal of "secondary prevention."

New Treatment Methods

State crippled children's programs have been responsive to the many new discoveries in medical diagnosis and treatment which have become available.

Rickets as a cause of crippling was already on the way out in 1935. Improved case-finding procedures and additional treatment facilities as well as pasteurization of milk and new antibiotics have dramatically reduced bone tuberculosis. Chemotherapy and antibiotics have also greatly reduced both the number and the severity of cases of osteomyelitis, an inflammation of the bone marrow. The new Salk vaccine promises to control poliomyelitis.

In the field of childhood cardiac disability the advent of sulfadiazine and penicillin have made possible the control of rheumatic heart disease, while the development of remarkable new operative techniques have opened the way to habilitation of over half of the cases of congenital heart disease.

During World War II many remarkable new ideas and procedures were developed which have boosted the whole field of rehabilitation. One of the most remarkable examples is the creation of a new medical specialty, clinical audiology, which has practically revolutionized previous thinking about "deaf" children and made it possible to provide auxiliary methods of communication to nearly all youngsters with impaired hearing for whom treatment is started early enough and maintained with the necessary intensity.

One of the most exciting recent developments has been the improved approach to upper- and lower-limb prosthesis, resulting from research spearheaded by the National Research Council and characteristically based on the team approach of orthopedist, physical therapist, and prosthetist.

Other exciting examples could be added to this list. But there is also another side of the coin, for sometimes the wonder drugs and improved methods of obstetrics and care of premature infants result in the survival of severely disabled infants. Nearly all program directors expressed concern about the increasing numbers of children in the categories requiring custodial care or institutional type of habilitation services. The solution to this problem would seem to be a "must" for the next decade.

The Ideal Program

Of necessity this cursory survey has simply highlighted certain significant advances. Crippled children's services still have far to go to reach the goal intended in the basic enabling legislation. Currently the Child Health Committee of the American Public Health Association is developing a number of "Statements on Recommended Practices in Programs for Crippled Children." When published these will be helpful in crystallizing current thinking on the best approach to the several types of handicaps.

Meanwhile Kobes[3] has recently offered us a definition of what a program should be:

"An ideal crippled children's program is one which has the broadest possible range of high-quality medical care and related services available to meet the needs of children who have a broad spectrum of medical diagnoses. These medical categories should perforce be those which are characterized by long duration of the effects of the handicapping condition and thereby cause an undue amount of drain on the family's energies and economic resources. Adequate payments should be made to all who render services, whether they be full-time staff members or part-time consultants giving clinical services. All families should make payments toward the cost of care within their ability to pay. All personnel should meet the highest possible standards of professional ability and performance. The health and medical-care services needed to obtain the best clinical results for each child should be made available, and the social, emotional, educational, and vocational-training aspects of each child's needs should also be the concern of those who have the responsibility of administering the State's crippled children's program. Whenever it is necessary to do so to insure a wide range of capable services, the State should provide training programs to help fill any gaps which may be present. Existing resources should be used to the fullest extent and without duplication of services. They should be improved whenever necessary to meet the most desirable standards of care, and only when existing resources are definitely proved to be lacking should completely new facilities be constructed. There needs to be sharing of resources among communities, even to the extent of working out interstate arrangements when it seems undesirable to make available for one State a service which may be used but rarely. Only when we know that we have a program which will bring the maximum number of physically handicapped children into our society as useful, productive members can we feel that our job is nearing its highest level of success and accomplishment."

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[1] Eliot, Martha M.: Symposium on Crippled Children's Services. The Journal of Bone and Joint Surgery, vol. 36A, No. 6, pp. 1259–1277.

[2] Davens, Edward M., M. D.: "Services for the physically handicapped child." In *Rosenau—Preventive Medicine and Hygiene.* Kenneth F. Maxcy, editor. New York: Appleton-Century-Crofts, Inc., 1951. (P. 710.)

[3] Kobes, Herbert R.: Symposium on Crippled Children's Services. The Journal of Bone and Joint Surgery, vol. 36A, No. 6, p. 1277.

PUBLIC POLICY AND CHILD WELFARE

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TWENTY YEARS AGO title V, part 3, of the freshly enacted Social Security Act expressed in law, for the first time in American social-welfare history the concept of a tripartite public responsibility for social services for children. While previous measures had given the Federal Government—and hence the country as a whole—at least a temporary responsibility for meeting some of the financial and health needs of children, this section of the new law introduced a concept of social service as something other than financial aid for children and something in addition to the services provided in child-health programs. It also opened the way for the development of public policies which have had a lasting effect on the shape of social welfare in this country.

These policies, *the official guides for program operations*, have arisen from two sources: (1) the directives spelled out in the act; (2) the regulations of the administrator (successively the Secretary of Labor, the Federal Security Administrator, and the Secretary of Health, Education, and Welfare) and the decisions of the administrative agency, the Children's Bureau. What these policies are and the effects they have had are worthy of some detailed examination.

Sometimes public policies are confused with the goals of a program, though in reality they constitute only the framework, or the structure, in which a program operates. Nevertheless they tend to a large degree to determine the nature of the program's achievement. Moreover, when they are particularly well formulated, they constitute a readymade pattern which can be used in the sound development of other, or future, programs.

Policies Set by the Act

The child-welfare-services section of the Social Security Act is a relatively short legal passage, with a considerable amount of its content devoted to procedures. However, within this short passage, as amended in 1946 and 1950, are to be found today four legislative requirements for participation in the program. All of them are significant to American social welfare. They specify that: 1) the task of providing increased social services for children be a joint effort of two levels of government; 2) the negotiations between each State and the Federal Government be based upon a State plan of child welfare; 3) the social-service needs of children in rural areas be especially considered; 4) the development of services include community study and organization.

What are the implications of these requirements?

1. Public responsibility for the development of social services for children is a joint effort of all levels of government. The act requires joint planning by State and Federal Governments and provides for the development of programs in behalf of children at both State and local levels. In effect, the Federal Government, as the result of the child-welfare-services provision of the Social Security Act, has been added to the "team" of planners of social services for children, but in no way takes over the role of the State and local Governments.

The language of the statute clearly expresses the intent: the Federal Government is to "cooperate" with the State in providing increased social services for children. In no way are State, local, or private expenditures for child welfare to be replaced by Federal funds. Rather, the Federal funds are to help "establish, extend, and strengthen" services for children.

2. The instrumentality for furthering social services for children is a State plan. To put in writing the specific aims and the operational means of achieving these aims has many values. Certainly the presence of a proposed plan provides a feasible and practical route for the State and Federal Governments to come together to deal with the expansion and improvement of services for children. Moreover, a well-written plan is valuable for its concreteness. Although revision is possible, it takes on the characteristics of a contract and enhances feelings of responsibility.

A State plan can also be the means of providing for greater representation and deliberation in the establishment of welfare goals. It can be generally conducive to the doing of first things first. In addition, as the years go by the plans can constitute a sort of "self-made" history of child welfare for the State involved. Read seriatim, they reflect changing and unchanging program goals, give an account of the various approaches that have been used in tackling problems, and show what has led to failure or to achievement.

3. The social-service needs of children in rural areas and in "areas of special need" are especially considered. The significance of the legislative directive which resulted in this policy lies in its universalization, in principle, if not in actuality, of the availability of social services for children. At the time of the passage of the act such services had been developed almost exclusively in cities. To provide for their extension to rural areas at that time was therefore a major effort to correct a welfare inequity in these United States. Great progress in reaching rural areas has been made. Now, 20 years later, there is an increasing demand that the children in urban as well as in rural areas benefit from the good things the program brings and that the scope of the act be broadened.

4. Engaging in community child-welfare organization is considered a proper and necessary activity in the course of establishing, extending, and strengthening local services for children. Here is the means by which a program of social services is truly geared to social needs. To establish a welfare program apart from sound community study, planning, and citizen participation is likely to result in services that are ineffectual and inefficient, and a static, rather than a dynamic program.

This danger was clearly sensed and warned against by those in close touch with the legislative plans. For example, a report of the Committee on Economic Security, contains comments like the following:

"Many kinds of services to children are needed which are not provided by an emergency-relief program, including, for example, investigations of children in almshouses and the development of plans for caring for them elsewhere; investigations of cases in which applications for institutional or foster-home care have been made; protection of children against neglect and abuse; development of plans for caring for children in institutions who have reached an age when they should be discharged and supervision of these children after discharge; investigation and supervision of delinquency cases coming before the courts; plans for securing needed medical attention for physically handicapped children and custodial care or supervision for children who are mentally defective. For effective operation local child-welfare programs should be closely related to family-welfare and relief programs and where possible should be part of a unified public-welfare service." [1]

Early Children's Bureau Policies

As already indicated, public policies come not only from legislation but also from the administrative agency which sets the guidelines for operation. Of the several major administrative decisions which the Children's Bureau made during the early or formulative period of the child-welfare services program, four were of particular significance from the viewpoint of social-welfare policy. They were: (1) that a broad definition of child welfare be applied in the consideration of State and local projects; (2) that there be an acceptance of variation in State plans rather than an insistence upon uniformity; (3) that qualified personnel be recognized as the core of a child-welfare program; and (4) that State and local governments be encouraged to conduct "child-welfare demonstrations."

What do these policies mean?

1. A broad and comprehensive definition of child welfare is used in considering State plans. From its inception in 1912 the Children's Bureau has construed the term "child welfare" broadly as concerned with all of the social aspects of child life. During the early years of the Federal-State child-welfare services program the director of the Bureau's Child-Welfare Division constantly reaffirmed that position, in such words as: "Child welfare in its broadest sense is the expression of a community's interest in fostering those social and economic forces which safeguard family life and insure to every child the fullest development of his mental, physical, and spiritual potentialities." [2]

Transposing this philosophy into administrative action means the acceptance and approval of many different types of child-welfare programs and projects. It means acceptance of the fact that there is more to social service for children than one or two standard brands of foster care. In actuality it means becoming a party to such proposals as adding another professionally trained social worker to the welfare department in Maine for providing voluntary agencies with consultation on standards, or establishing a psychiatric consultation service for rural areas in California. In short, it means that "diversity in unity" is a practical possibility in American public welfare.

2. There is an acceptance of variation in State plans rather than an insistence on uniformity. This second policy is a necessary corollary to the first. The great range of differences in American life calls for acceptance of variation—possibly great variation—in State plans. More important, the policy arose from the firm conviction that, to be sound, the growth of services in rural areas and cities all over America, would have to begin at that point, developmentally, where each State or each locality happened to be. Thus, from the beginning, there has been little attempt to arrive at a common pattern of child-welfare services.

It may be that in thus encouraging considerable leeway in State plans, the Children's Bureau has effected its most important achievement in public-policy formulation. For in this way it has demonstrated that a Federal grant-in-aid arrangement need not intrinsically and inevitably result in uniformity. If anyone still has this fear, let him read a random selection of State child-welfare services plans for any year from 1936 to the present.

3. The use of qualified personnel is emphasized in the performance of all the undertakings proposed in child-welfare services plans. By holding unswervingly to this conviction, the Children's Bureau has contributed greatly to the improvement of child-welfare personnel throughout the Nation. Administratively this has been accomplished in two ways: 1) by encouraging the States to hire well-qualified persons in so far as possible; 2) by encouraging States to write into their plans a provision for staff-development activities, including educational-leave arrangements to enable local persons to attend graduate schools of social work.

In addition to raising the personnel standards for child-welfare services, this emphasis on competence has paid off in other ways. In many instances the addition of professionally trained child-welfare personnel to State and local public-welfare offices, the presence of in-service training opportunities and the possibility of educational leave for promising workers, has served as a leavening force in raising personnel standards throughout the whole public-welfare system.

4. Local and State communities are encouraged to conduct child-welfare demonstrations. This early policy, now receiving less emphasis than in the beginning, emerged almost imperatively from the limitation in the funds and the general lack of development of community child-welfare services in many parts of the country, especially the rural areas. The demonstrations were, for the most part, simply a "trying-out" of a variety of social-service programs for children in order to secure community support. They made it possible for a rural community to gain the practical experience or wisdom for sound thinking about the services children need. They provided an opportunity of seeing at first hand both the positive and negative features of particular projects, thus giving the citizenry a basis for choosing intelligently the programs they would "buy" on a permanent basis.

Now that more funds have become available, both Federal and State, and since each State has at least the nucleus of a child-welfare program, the Bureau has revamped its emphasis on "demonstrations" into an emphasis on "growth," encouraging States and localities to establish activities that will extend and improve their going programs.

Subsequent Policies

Since the 1935 formulation of the child-welfare-services section of the law and the early administrative decisions of the Children's Bureau, only a few major policy changes, either legislative or administrative, have come about—a fact which bespeaks the careful thought that went into those initial stages of creation. Apart from increased appropriations only two major policy additions *have been put into the act itself*. One is a proviso allowing States to use Federal child-welfare-services funds to meet the cost of returning runaways to their States of residence. The full significance of this somewhat particularistic provision is yet to be determined.

The second policy addition is contained in an amendment to part 3 of title V, made by the Congress in 1950, which states: ". . . in developing such services for children the facilities and experience of voluntary agencies shall be utilized in accordance with child-care programs and arrangements in the States and local communities as may be authorized by the State." The two Houses of Congress, in conference on the 1950 amendments, had agreed that the States would be "free, but not compelled," to utilize the voluntary agencies' facilities and experience.

Actually the practice of encouraging States to work cooperatively with voluntary agencies in the development of their child-welfare plans had been in effect in many places from the beginning of the program. In fact both the Children's Bureau and the States had assumed that such cooperation was a proper and necessary phase of engaging in sound community organization for child welfare. Evidence of this can be found in the document *Child Welfare Services Under the Social Security Act, Development of Program*, 1936–38 (Children's Bureau Pub. 257, 1940). Moreover, in 1936 the Children's Bureau Advisory Committee on Community Child Welfare Services had emphasized the importance of close cooperative action between public and private agencies in a resolution which reads in part: "State and local administrative units should recognize the necessity of utilizing the various services available for children and relating child-welfare services, leisure-time and recreational activities, and other public and private agencies which exist or can be developed in their territories."

From the viewpoint of public-policy analysis the new legislative statement has had a clarifying effect. It is a good thing for Congress to have taken this action as it helps to strengthen the work for sound community study and planning in the development of a Federal-State-local social-service program for children. It is especially good, considering that in the early days social services for children were too frequently developed in isolation rather than coordinatively.

The only other major policy change during the past 20 years came with the Children's Bureau's modification of its earlier position that Federal child-welfare funds should be spent for services only, rather than for maintenance. The logic of this early restriction on expenditures, adopted on the recommendation of the advisory committee, stemmed from the meagerness of the original appropriation, $1,500,000 for all States and Territories. To have used the funds to pay for the costs of child care in foster homes or institutions would have robbed the program of the means of improving and increasing personnel and of conducting needed demonstrations, while only an insignificant increase could have been made in the total number of children receiving care. However, as Federal funds have increased, a change in position became possible. Today State plans for child-welfare services may include expenditures for direct care of children through programs of foster-family or group care, day care, and care of unmarried mothers; and special care for individual children; and in fact for any type of care or activity that comes within the generally accepted program of child welfare.

Achievements

The achievements of the Federal-State child-welfare services program over 20 years have been many. As thousands of children have been served without reference to a means test, the equality of opportunity for children in this country has been enhanced. Through the operations of this program the concept of social services for children has broadened so that the once dominant foster care, though still important, is only one part of a totality of services. Over the years these operations, along with the operations of the other grant-in-aid programs of the Social Security Act, have permitted the accruement of a valuable experience in the know-how of intergovernmental relations. Twenty years of community planning and organization stimulated by the program have resulted in a rich experience in cooperative action between public and voluntary agencies in serving children. Twenty years of emphasis on the importance of competent personnel has resulted in widespread recognition of the special skill and training needed by persons providing social services to children.

Apart from, and interrelated with, these and other gains of the past score of years stands the achievement in public-policy formulation. Those public policies—stemming from the law and from administration—constitute in their own right a methodological contribution to American social welfare. When analyzed, shorn of program specifics, and articulated, they can constitute a pattern of government operation which is compatible with the American culture and which tallies with a democratically oriented people. When people are not uneasy about the means, they can use their time, energy, and their wisdom in the better refinement and the expansion of the goals of social betterment.

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[1] Social Security Board: Social security in America; the factual background of the Social Security Act as summarized from staff reports to the Committee on Economic Security. SSB Pub. No. 20. Washington, D. C. U. S. Government Printing Office, 1937. 592 pp. (p. 255).

[2] Atkinson, Mary Irene: Social trends in child-welfare programs. *In* Mary Irene Atkinson speaking for children. Cheney C. Jones and Gertrude Springer, editors. Nashville, Tenn., Parthenon Press. 1949. 192 pp. (p. 141).

DIRECTIONS IN CHILD WELFARE PROGRAMS

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A SIGNIFICANT evolution has been taking place in social services for children during the last two decades which holds solid promise for the future.

Many child-welfare programs have broadened their conception of the children whom they wish to reach. Methods of working with and for children have changed. New uses for different types of treatment and care have been developing. Relationships between child-welfare workers and other professions working with children are becoming more frequent and meaningful. Most important, perhaps, has been the growing acceptance of the principle that, to be effective, social services for children must be based in the local community and encompass its total child-welfare needs.

Forces within and without child welfare programs have affected this evolution. Years of depression, war, and international tensions have left their marks on all social life. These experiences have helped to determine and refine the function of these programs for children. Many developments must be credited to the greatly enlarged knowledge of the nature of human development and behavior which has come out of the clinics, laboratories, field tests, and observations of all the social and medical sciences. The ability of child-welfare workers to deal effectively with human problems has grown progressively keener as the concepts from these other sciences have been woven into practice. Changing attitudes toward society's responsibility to back up the individual's economic and social health have helped along this evolution in child-welfare programs. And last, but not least in order of importance, public programs have had the financial support of all levels of government for the first time in their history.

Twenty years ago when the Congress, in response to widespread need, included Part 3, Title V, in the Social Security Act it authorized grants to be given the States for the purpose of establishing, extending, and strengthening social services for homeless, dependent, and neglected children, and those in danger of becoming delinquent in rural areas and in areas of special need.

Significantly, the Act imposed no limitation on the economic status of the children who might be served by programs aided with Federal funds. The money was to be used to develop programs of the broadest scope and highest possible standards—"adequate methods of *community* child welfare organization," the Act stated. The Congress looked to the Children's Bureau, which was made responsible for administering the grants, to give lift and leadership to the States in developing such programs.

Federal Grants

At their start, Federal grants were fixed at $1,500,000 annually. This amount was raised to $1,510,000 in 1939, to provide help to Puerto Rico; and to $3,500,000 in 1946 as costs of service mounted and the child population increased. In 1950, the Congress lifted the ceiling once more, to $10,000,000 annually. Appropriations since then, however, have never exceeded $7,600,000.

Over the years, as the child population has grown, and as pressures for help for disadvantaged children have intensified, the Children's Bureau reports, States and communities have assumed an increasing proportion of the program costs. For example, in the fiscal year 1954, State and local public-welfare agencies spent a total of $126 million from their own and Federal funds. Of this, 28 percent went for professional and facilitating services, and 72 percent for direct foster-care payments. One-fifth of the former stemmed from Federal sources. Less than 1 percent of the latter came from Federal grants.

Some States, with no pattern of public programs for child welfare in 1935, had to start from scratch. Others built on what they had, though much of it was spotty. In the years since, no single State has yet achieved a completely rounded program for all children throughout its area who need these specialized services. But every State is moving toward these objectives.

Before 1935, both public and private child-welfare programs were little known in rural areas. What programs there were existed almost exclusively in cities. Only a few States had private statewide organizations attempting to spread services locally throughout their areas. About half had some type of State-administered activity, but on an extremely limited basis.

Today, the Children's Bureau reports, all 53 political subdivisions of the Nation are participating in public child-welfare programs. More than 50 percent of the counties, in which 74 percent of the Nation's children live, have the service of at least one full-time public child-welfare worker. In June 1954, there were 3,850 such workers. Steady progress toward total coverage of all States, though greatly needed and much desired by the responsible agencies, is directly related to the availability of additional funds, local, State, and Federal.

From the beginning, each State has made its own plan, within the provisions of the Act, for using Federal funds in the ways best suited to its needs and resources. All States have been free to call on the Children's Bureau for technical consultation, and all get help in firming up their annual plans for the use of Federal grants.

Because grants were small at the start, it was believed in the beginning that they should be used in the main to employ trained child-welfare workers, and not to finance the support of children in foster care or to pay for other types of direct care. Since 1946, and particularly since 1950, however, with increasing annual grants, this restriction has been lifted and States are using a small part of their Federal money to pay for the support of children in foster care. Some expenses involved in returning runaway children to their homes have also been met since 1950.

Broadened Scope

Before these expanded programs got under way, children served by public-welfare programs were principally those for whom foster care in homes or institutions must be found, children born out of wedlock, and children referred by courts to public-welfare agencies because of delinquency charges, or because of neglect or abuse on the part of their parents. Too often, child-welfare workers were called in, after the fact, to do what they could to help rectify damage already done to children.

These responsibilities continue to absorb much of the time of public child-welfare workers. The ways in which they work, as described later, have undergone much change. Increasingly these public programs are proving helpful to children with the usual run of social problems and to those more seriously disturbed.

With the continued employment of millions of mothers outside the home since World War II, day care for their children is urgently needed, and here and there public-welfare programs are cooperating with private agencies in furnishing this service. Frequently, the public agency stimulates such service under private auspices and helps to raise the standards of both public and private groups.

When mothers must be away from home because of hospitalization or other causes, in some places programs to provide homemakers, working under the supervision of a child-welfare agency, are keeping children together in their own homes until mothers return. Many new uses are being discovered by both health and welfare workers for this valuable new "homemaker service," again more frequently found in private, than in public, programs.

Increasingly, families and individual adults are turning to child-welfare agencies for help for children with serious emotional difficulties. Such difficulties may be related only in part to the demeaning poverty in which a child is living. Many of these children are still in their own homes, and in homes of all economic and social levels. The day is passing when public and private child-welfare programs are concerned only with the child of poverty, the child of a broken home, the child born out of wedlock, or the child who is delinquent.

No adequate yardsticks have yet been developed for measuring the total number of children helped by both public and private agencies, nor the financial contribution to their treatment and care assumed by each. Some baseline figures covering part of child-welfare services were given by the census of children in foster family homes and institutions in 1933. At that time, there were 249,000 such children, 29 percent of whom were in the care of public agencies. Twenty years later, public agencies were caring for 50 percent of the 265,000 children in both kinds of foster care. Both public and private agencies, however, help many more children than these figures indicate. The caseload of private agencies, like the public ones, reflect the increasing importance that both place on helping children in their own homes thus diminishing to some extent the need for foster care. On December 31, 1954, of the 277,000 children reported to the Children's Bureau as receiving casework services from public child-welfare agencies, 41 percent were living in the homes of their parents or relatives. By far the largest share of work with delinquent children, outside their own homes, throughout the 20 years, has been borne by public agencies. In contrast, a large share of the care of dependent children in institutions has been carried by voluntary agencies.

Regardless of the proportion of total responsibility carried by public and private agencies, developments in the one intimately affect the other. Throughout the 20 years of federally-aided public programs there has been cross-fertilization of philosophy, methods of work, and experience which has been enriching to both public and private services. To map the directions, then, in which these services have been moving in these 20 years, it is necessary to take a broad look at them, regardless of their sponsorship.

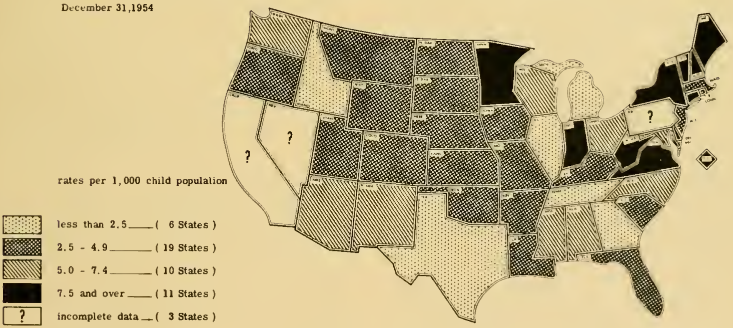
Probably no single route that child-welfare services have taken in these years is as significant as its steady march toward cementing and bulwarking the life of the family as a unit of strength in our society. This represents a major change from earlier days when the principal preoccupation of child-welfare workers was, figuratively, to pick up the pieces when families had failed their children in one way or another, and to find new homes for them.

In our culture the family has always been recognized as the social institution that figures most importantly in children's lives. Its economic function in providing its members with the physical necessities of life has often been overemphasized. When the depression of the 30's deprived millions of workers of the opportunity to live up to this expectation of them, social ways and means of providing economic security for families were found. In recent years, as employment has remained relatively high, and as public measures for strengthening the family's income have become more adequate and inclusive, the deeper values of family life have received more attention.

This shift in focus has been greatly helped by the insights that psychiatry and the social sciences have contributed and, many believe, by a greater appreciation of spiritual values. Acutely aware of the deep significance, in personality development, of sustained parent-child, and especially of mother-child, relations, the modern-day worker seeks to preserve these relationships as long as they have any positive values for parents and child. Only when they cease to have any such potentials should children be removed from their own homes, and then for no longer than the situation warrants.

When children are to be placed in foster care, today's worker no longer looks to this as the terminal

WHERE CHILDREN ARE RECEIVING PUBLIC CHILD-WELFARE SERVICES


December 31,1954
?
?
?
rates per 1,000 child population
less than 2.5 (6 States)
2.5 - 4.9 (19 States)
5.0 - 7.4 (10 States)
7.5 and over (11 States)
? incomplete data (3 States)

point in his help to the child or his parents. During the child's absence, whenever possible the worker makes himself the link between the child and his own family, and the link between his own familiy and the foster family or institution that is caring for their child.

This new awareness of psychiatric concepts has led workers to make other changes in practice. With their keener understanding of motivation in human behavior, workers realize that the action a parent or child takes in his own and in each other's behalf may count for far more than any solutions a worker may devise. Accordingly, parents are helped to participate in all decisions affecting their child, even the decision as to whether they shall be separated. The child's right to a substantial degree of "self determination" is also respected. It is the worker's function to point out choices, to help parents and children come to grips with alternatives and with the results of the choices they make. When placement elsewhere is necessary, parents are helped to see this as an expression of their own responsibility and not an admission of failure. By helping families build their own internal strengths, today's worker finds that the removal of a child to foster care can often be avoided, or that time away from home can be shortened if not avoided entirely.

Reflections of New Knowledge

Changes in the whole adoption field are another reflection of the newer knowledge of a child's emotional and social growth. The infant's greatest emotional need, it is now believed, is to acquire a sense of trust in others, and that comes best from continuous attachment to a single "mother-person." Accordingly, workers are questioning whether the placement of babies in adoption should be delayed for psychological tests or other reasons. They are speeding up the interval between the natural mother's release of her baby and his arrival in his new home. They are finding that some babies, previously thought unsuitable for adoption because of possible retardation, show a marked improvement in mental development when placed at an early age. In many places workers are finding adoptive homes, too, for older children who are physically and mentally handicapped, and seeing them blossom in their new environment.

Sensitive to the effect of a child's relationships on his emotional health, today's workers attach more importance than ever to specialized uses of foster-family and institutional care for children. Some foster parents have unique skill in dealing with children emotionally disturbed, and workers are using these homes as treatment for both children and their own parents.

Many child-caring institutions are reexamining their programs. For some years there has been a trend away from institutional care for infants and preschool children and toward foster-home care for these age groups. On the other hand, it is now seen that some older children do best in a group setting provided by good institutional care. Such care, when adequately provided, proves to be an effective treatment method for many of those who are emotionally disturbed, retarded, delinquent, or in need of emergency shelter. The congregate type of institution, which places children in large groups where individual care and treatment is difficult, if not impossible, still exists. But more and more, institutional care is being transformed into highly specialized care of small groups of children with similar problems.

Methods of locating children in need of help are also undergoing change. Twenty years ago, the test of a person's readiness for help was usually a knock on the door of a child-welfare agency. As psychiatric concepts have influenced casework, workers are realizing that the old test was not sufficient. More of them are now going out to people, and going out with better understanding of what motivates people to both ask for and accept help.

In his practice, the modern well-trained caseworker brings to bear on the problems of the child a body of knowledge and experience out of which his own personal prejudices, insofar as possible, have been distilled. He has the conviction as well as knowledge that all human behavior is meaningful, that people should be helped to carry out their own desires when these are socially desirable, that the authority imposed in a child-welfare worker has "positive" uses and is not to be employed in pushing people around; that at all times the use of one's professional self must be objective, disciplined, and warm.

No longer is casework the only method child-welfare agencies use. Increasingly, agencies are dovetailing their casework with group work in behalf of the child with serious problems. These complementary ways of working with the child, both as an individual and as a member of a group, are often found to be more productive in helping him handle his emotional and social problems in a more constructive and satisfying way.

Community organization, too, is becoming an important aspect of child welfare. It is evident that in planning and providing services for emotionally ill and socially maladjusted children, child-welfare programs must integrate their efforts with other social, health, mental health, educational, court, and recreational agencies. These efforts have three objectives: (1) to achieve better cooperation in meeting the varied needs of each child; (2) to promote services that are lacking; and (3) to anticipate and prevent the beginnings of social and emotional illness in children.

These, then, are some of the important directions child-welfare work is taking as the first 20 years of federally aided public programs are rounded out. Of course their routes are traveled to a greater or lesser degree by the advance guard of agencies and workers. Many of those who lag do so, not because of lack of vision, but because of inadequate public understanding and financial support.

The miracle is that so much has been accomplished with so little. Throughout their history, Federal grants, when divided among 53 departments of public welfare, have been modest, indeed. The lion's share of State and local funds have had to go to meet the cost of supporting children in foster care. The burden of this cost is far from equally shared between the three levels of government. When the Federal Government assumes its rightful share of this long-time and integral part of child-welfare programs, helping to make improved services and facilities available to all children who can benefit from the varied forms included in the single term "foster care," then both health and welfare programs for children will be able to move ahead much faster.

One fact, above all others, behind such progress as these welfare programs have been able to make in the past deserves emphasis. They have held high the torch for professional competence on the job. Many State agencies have done a heroic job of staff development, through training on the job and through underwriting graduate education.

Since 1950, from 7 to 10 percent of Federal child-welfare funds have been used for training workers. Forty-five percent of all child-welfare workers employed by States have one year or more of graduate professional education. Most of the remaining 55 percent are at least college graduates. The goal for the States continues to be 2 years of professional education for all.

The Job Ahead

What is the wave of the future for these services for children?

Its curve, direction, and momentum have been excellently forecast for itself and its affiliates by the Child Welfare League of America. Out of 2 years of searching and effective self-study has come an admirable publication, "Today and Tomorrow," which merits the study of all who are working in this field.

The ideas that follow have been suggested and refreshed by the League's "look ahead."

1. There still is a big job to do in bringing the most backward child-welfare program up to the level of the most advanced, and to extend the most advanced so that the many thousands of families and children who need help, in cities as well as in rural areas, can get the best.

2. There is still a vast body of State laws on statute books that have been long outmoded by new knowledge and practice. These urgently need to be brought up to date in line with modern professional thinking.

3. Much remains to be learned about ways of detecting social and emotional ill-health in children, about poor relationships between children, about effective methods of reaching people, about the nature of purposeful relationships among people.

4. Child-welfare programs will move ahead more constructively if they ally themselves continuously with services for children under other auspices; with those attending to the education of exceptional children; with those providing mental health, child guidance, and parent education programs; with medical services and health programs; with programs for family and community recreation; and with agencies dealing with delinquent children.

5. Everlastingly, child-welfare workers must help to shape public attitudes: (1) toward accepting the principle that child-welfare programs are for all who need them, regardless of income or other considerations and (2) toward giving these programs more adequate financial backing.

CHILDREN AND THE ASSISTANCE AND INSURANCE PROGRAMS

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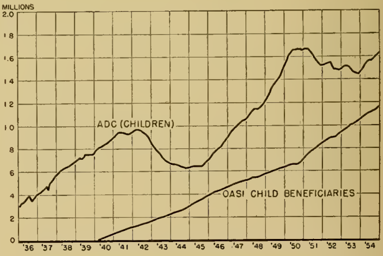
ONLY IN THE PERSPECTIVE of the past 20 years is it possible fully to appreciate the tremendous contribution of the Social Security Act to the economic support of children. Since 1935, when the first social security legislation was enacted, more than $8 billion have been spent for the maintenance of millions of families under two programs with provisions specifically designed to afford economic security for children deprived of parental support or care. These are the aid to dependent children's program, financed from Federal, State, and local funds, and the federally administered program of old-age and survivors insurance, financed from payroll taxes levied by the Federal Government on employer and employee alike. With respect to children, these two income-maintenance services have the same major objective: To enable the family deprived of its regular support to hold together so that the child may have as normal a family life as possible.

In addition, other income-maintenance services authorized by the act contribute significantly to the well-being of a substantial segment of the child population. Old-age insurance benefits as well as assistance for the aged, blind, and permanently and totally disabled, lift a heavy burden from the shoulders of parents in low- and moderate-income families who otherwise would find it necessary to support the older as well as the younger generation. Unemployment-insurance benefits afford an economic underpinning for families when a labor-force member is out of work and thus add to the stability of family life. For countless children these measures make possible a higher standard of living and a higher educational level than would otherwise be attainable.

Federal legislation relating to aid to dependent children is an outgrowth of State enabling laws for "mothers' aid" or "widows' aid" which were enacted in 46 States between 1911 and 1934 and were commonly permissive with the counties. Special legislation for supporting needy children on loss of the main breadwinner emerged as part of a broader movement to break away from the old poor laws and to grant aid on a more self-respecting and stable basis to certain needy groups beyond the limits or on the fringes of the labor force. The Federal-State programs for dependent children were influenced not only by these early mothers' aid programs but by experience under temporary legislation with Federal

CHILDREN RECEIVING ADC AND OASI



Number of child recipients of ADC and OASI 1936–1954.

grants to States for emergency relief in the depression years 1933–35.

The decision of the Federal Government to assume a share of the responsibility for financing aid to dependent children on a continuing basis has resulted in greatly strengthening and extending State programs for dependent children. When Nevada's recently enacted law goes into effect, such aid will be available in all local subdivisions of the Nation. Under the earlier State enabling laws less than half of the counties authorized to administer mothers' aid actually had programs in operation. For the most part the early programs were financed entirely from local funds, which often were grossly inadequate and unstable. Conditions of eligibility, moreover, were generally relatively restrictive.

In contrast to direct financial aid, broad social-insurance protection for children is a comparatively new development in the United States which emerged with recognition of the importance in an industrial economy of protecting earners and their dependents against economic hazards. While the original Social Security Act provided only for retirement benefits in old age the 1939 amendments authorized benefits to children under 18 of retired or deceased workers. The first OASI benefits were paid in 1940.

Persons Served

Aid to dependent children, which, when the Nevada law takes effect this year will be granted with Federal help in all States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands, provides cash income on the basis of individually determined need to children in families who are deprived of support or care by reason of the death, mental or physical incapacity, or continued absence from the home of either parent. To be eligible for aid with Federal participation the child must be under age 16, or 18 if he is regularly attending school. In addition, the child must be living with a parent, grandparent, brother or sister, uncle or aunt, or other close relative.

In old-age and survivors insurance, with a nationwide spread, benefits are provided as a matter of right, without any test of need, for a child under 18 on the death of the father, or of the mother if the child has been dependent on her for support. The deceased parent, of course, must have had insured status, which may be acquired with as little as 1½ years of covered employment within the 3 years preceding death. A child of an aged father or mother receiving old-age benefit is also entitled to a benefit. Benefits are usually paid to the mother in behalf of the child of the deceased worker but may be paid to someone else who will be responsible for using the benefit in his best interest. Although practically all children with benefits are in a family setting some few are living in institutions.

Both programs provide some support for the mother. In ADC a needy mother or other close relative with whom the child lives may receive aid. The mother of a child entitled to an OASI benefit may have one in her own right until the child reaches age 18, if she does not remarry and has no substantial earnings.

Program Coverage

Although the general pattern of State ADC programs is set by the Social Security Act, the act nevertheless affords the States wide latitude for determining who shall be eligible for aid. It does not define many of the basic requirements for eligibility, such as "need," "incapacity," and "continued absence from the home," but leaves them as highly elastic concepts to be construed narrowly or broadly.

Similarly a State may establish narrow or broad provisions relating to age, school attendance, and the specified relatives with whom the child may live. Although the act permits a State to impose a State residence requirement of 1 year and a requirement of United States citizenship, 10 States do not require any specified period of residence in the State; Texas, a border State, is the only State to require United States citizenship. States have the option of establishing other conditions of eligibility provided that they do not contravene the Federal act. Among State-imposed conditions of eligibility are some relating to employability or employment status of the parents or children, "suitability of the home," "fitness of the parent," and, in the case of desertion or abandonment of a child by a parent, the filing of a complaint by the remaining parent to compel support.

In contrast, under the social-insurance program, a child's entitlement to benefits is based on the parent's work record in covered employment and is thus determined on a uniform basis throughout the Nation. Today 9 out of 10 workers are compulsorily covered under the system or are eligible for coverage under special arrangements. Because of past limitations on types of work covered, however, old-age and survivors insurance has not in the past afforded equal protection to children in all parts of the country.

The original Social Security Act covered industrial workers mainly. Farm operators and farm workers, domestics, the self-employed, Government workers, and certain other groups were excluded from coverage until the more serious gaps were plugged by the combined effects of the 1950 and 1954 amendments. In future years orphaned children in different sections of the country will have substantially equal chance to qualify for child's benefits. The agricultural South, particularly, has been heavily penalized by the earlier exclusion of farm groups.

In December 1954, more than 1.6 million children in nearly 600,000 families were receiving aid to dependent children—29 per 1,000 under 18 in the Nation's population. In nearly nine-tenths of the families the mother or other caretaking relative also received aid. In Puerto Rico, which has very limited economic resources and widespread poverty, the rate was 107 per 1,000; at the other extreme, in New Jersey, which is a highly prosperous industrial State, the rate was 9. If Puerto Rico's meager assistance payments (about 10 cents per person per day) were more nearly adequate, the rate would be substantially higher. New Jersey's low rate may be ascribed partly to its favored economic position and its industrial character which has made for widespread OASI coverage. It is the only State in the Union, however, to limit ADC eligibility to children who are deprived of support or care by reason of the death, incapacity, or absence from the home of the father only.

At the end of 1954 nearly 1,200,000 children—or 21 per 1,000 under 18 years of age—were receiving OASI benefits. The State rates ranged from 6 in Puerto Rico and the Virgin Islands and 10 in North Dakota to 29 per 1,000 children in West Virginia. Puerto Rico and the Virgin Islands were not covered by OASI legislation until 1950 and hence only a small proportion of their paternal orphans are entitled to benefits. West Virginia's high rate may be ascribed in part to the hazards of the mining industry.

Reasons for Deprivation

At the end of 1953 death of the father accounted for the deprivation of support in over 17 percent of the ADC families. In more than 21 percent, the father was incapacitated. Estrangement of the parents ending in divorce or legal separation, separation without court decree, desertion, or unmarried parenthood accounted for nearly 54 percent of the families' dependency. The children were living with a stepfather not legally responsible for their support in 1 percent of the families. In the remaining 7 percent the father was in the home, in a correctional institution, or elsewhere, for example, away seeking work or, rarely, in the Armed Forces.

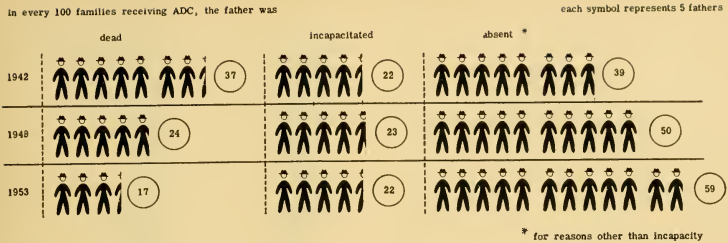
Of the children receiving OASI benefits at the end of June 1954, almost 97 percent were awarded benefits on the father's record. About 9 percent of these were children of fathers receiving old-age benefits, 91 percent were paternal orphans. Of all the paternal orphans in the continental United States 53 percent were receiving OASI benefits.

Basis of Payment

States may make ADC payments under aid to dependent children larger or smaller than the amounts specified in the act, but the Federal Government will not share in that part of any payment which goes beyond $60 for a family consisting of one adult and a child plus $21 for each child beyond the first. Within these maximums the Federal share is four-fifths of the first $15 of the average payment per recipient and one-half the balance. If a State makes payments larger than these amounts, it bears the full cost of the excess. As the formula operates, the higher the level of payments the lower the Federal share; the lower the payment, the higher the Federal share.

The size of an individual ADC payment is intended to represent the amount that a family needs, in addition to its other income, if any, to enable it to obtain such essentials as food, shelter, clothing, household items, and medical care. This amount is ordinarily reached by a budgetary measurement supposedly calculated to support families at a "health and decency," "maintenance," or "subsistence" level. Actually very few States provide assistance as adequate as this. Budgetary standards are commonly too low and frequently are not the final determinants of allowances.

Because of fund limitations, some States do not meet need in full as determined by their budgetary standards, but only up to specified amounts that vary with family size. In September 1953 a total of 31 States had set such maximums. Some States established maximums identical with the top amounts to which the Federal matching formula can be applied; others had maximums that were more or less liberal. Twenty-two States limited the total that could be paid to a family regardless of size. These family maximums ranged from $50 in Mississippi, which has the most meager economic resources of any State, to



CHANGE IN STATUS OF FATHER IN ADC

Death of the father has declined as a factor in the ADC caseload, while the father's absence from home has increased substantially. Families not represented above (3 percent or less) received ADC because of the status of the mother.

$387 in prosperous California, which has per capita income 2½ times as large as Mississippi's. Some States permit the maximums to be waived in certain instances of exceptional need.

Under old-age and survivors insurance, survivors' benefits vary according to the insured worker's previous level of earnings. The amount of the benefit is determined by a formula which is applied to the worker's average earnings up to $350 a month. The maximum monthly benefit for a family is $200. If there is only one survivor the minimum benefit is $30. A widow and 2 children would receive benefits of $82.50 monthly if the father's average wage was $100 and $197.10 if the average wage was $300.

Size of Payment

The average monthly payment per family under the aid to dependent children program, including both the children and needy adult caretakers, was $86.24 in December 1954. The State averages ranged from $26.20 in Mississippi to $139.70 in New York. In the Virgin Islands the monthly grant averaged $23.57 and in Puerto Rico $10.22. Federal participation in assistance payments is less liberal in Puerto Rico and the Virgin Islands than in the States and Territories, despite their smaller economic resources.

There is, of course, wide divergence in the amounts paid to individual families. These reflect differences not only in the family resources but also in the number of recipients per family. In September 1954, 89 percent of the families on the ADC rolls consisted of an adult recipient and 1 or more children; in the remainder of the families, the needs of the caretaker were not budgeted. The average number of children per family was slightly under 3. Nearly one-fourth of the families had 4 or more children and nearly one-fifteenth had 6 or more children.

In the OASI program families consisting of 1 or more children, with or without a dependent adult beneficiary, were receiving family benefits averaging $69.70 in December 1952. Average benefit amounts ranged from $79.30 in Michigan to $56.26 in Mississippi and $52.06 in Puerto Rico. State differences reflect differences in wage levels and the extent to which the States' occupations have been covered in the past, as well as variations in family composition. Of the family benefits paid in December 1952 slightly more than one-tenth were under $30 and less than one-half were under $60. More than one-tenth of the families had benefits ranging in amount from $120 to $168.75. By 1954, the average survivor benefit for one child was $42.20; for a widow and one child, $91; and for a widow and 2 children, $112.70.

As a result of both the 1950 and 1954 Social Security Act amendments benefit levels are now somewhat higher than in 1952. According to estimates, in January 1955 the average benefit for a widow and 2 children was $126, more than $13 above the 1952 amount.

Payments and Price Changes

Public assistance over the years has proven itself remarkably sensitive to price changes. During the war years sharp declines in ADC caseloads enabled States to raise payments as prices moved upward. Amendments to the ADC provisions of the Social Security Act in 1946, 1948, 1950, and 1952 liberalized the Federal contribution and helped States to keep payments abreast of the rising cost of living in the postwar years and even to raise their standards of assistance slightly. The 1950 amendments for the first time provided specifically for Federal sharing in assistance for an adult caretaker.

In contrast, the benefit structure in old-age and survivors insurance has until recently been unresponsive to changes in consumer prices. A benefit once awarded is not subject to change unless the act is amended to liberalize the benefit formula. From 1939–50 no changes in benefit formulas occurred. However, average benefits rose during the period because of rising wage levels in the war and postwar periods. All benefits have since been liberalized by a succession of changes in OASI legislation in 1950, 1952, and 1954.

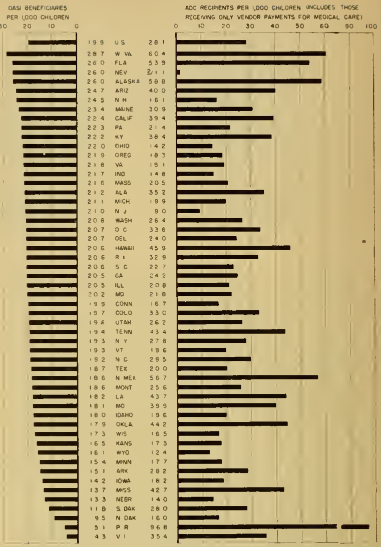
Relation of OASI and ADC

Supplementary assistance is sometimes needed by OASI beneficiaries when there are large numbers of children in the family, when there are exceptional expenses, such as the need for hospitalization, or when the benefit amount is small. At the end of 1953 about 6 percent of the families on the ADC rolls were also OASI beneficiaries. Of the children receiving OASI benefits, slightly more than 8 percent also were assistance recipients. In Iowa, Maine, Massachusetts, Michigan, New Hampshire, Ohio, Vermont, and Wisconsin, one-tenth or more of all ADC families had social-insurance benefits.

The character of the ADC program has been changing over the years as its responsibility for providing income to families whose chief breadwinner has died or is aged has been increasingly assumed by the insurance program. In 1942 there were only 18 child OASI beneficiaries for every 100 ADC children. By 1948 this rate had increased to 49 per 100. Now it is 71. With similar economic conditions in the next decade the number of child beneficiaries in relation to the number of ADC children may be expected to rise substantially.

The result is that to an increasing extent ADC is becoming a program for children whose deprivation of parental support is the result of the inability or failure of a living parent—usually the father—to assume a normal parental role. Whereas in 1931 about 82 ADC families in 100 were those of widows, in 1942 there were 37 such families in 100, and in 1948 there were 24. In 1953 the father was dead in only 17 families out of 100. Proportionately the number of families with an incapacitated father has remained fairly constant, representing a little more than one-fifth of all ADC families. But as the proportion of families with the father dead has declined, the proportion of families with a living father absent from the home has increased. Such families comprised 39 percent of the total in 1942, 50 percent in 1948, and 59 percent in 1953.

ADC AND OASI



1/ BASED ON DATA ESTIMATED BY BUREAU OF PUBLIC ASSISTANCE AS OF JUNE 1954
2/ PROGRAM ADMINISTERED WITHOUT FEDERAL PARTICIPATION

This changing character of the ADC program has led States to develop services related to the major problems confronting the types of families now in the caseload. Experience in the new Federal-State program of aid to the permanently and totally disabled has demonstrated the constructive values of thoroughgoing medical diagnoses and the evaluation of medical and social information by a team consisting of a physician, medical social worker, and rehabilitation specialist, in planning for treatment, rehabilitation, or training of an incapacitated father. Greater emphasis is generally being placed on cooperation between public-assistance and vocational-rehabilitation agencies in restoring such fathers to self-support when possible.

Welfare officials, the public, and legislators alike are disturbed at the increase, both absolutely and proportionately in ADC families with absent fathers. The increase in the actual number of such families stems both from increase in the number of families with children in the population as a whole and from increase in family breakdown generally. The unrest of our time is reflected in high divorce, separation, and illegitimacy rates generally. Some persons even fear that the availability of aid to dependent children provides incentives for family dissolution and unmarried parenthood but such an attitude would seem to represent a highly superficial view of behavior that has far deeper roots.

In 1950, Congress amended the act to require a State, as a condition to the receipt of Federal funds, to notify the appropriate law-enforcement officials whenever aid has been furnished in respect to a child who has been deserted or abandoned by a parent. This provision, commonly referred to as the "Noleo" amendment, places no additional responsibility upon law-enforcement officials, but the notices aid the law-enforcement officials in identifying situations in which action should be taken against the absent parent to obtain support. It is too early to know the results of the amendment, which became effective in July 1952, but there is evidence that some women are unwilling to have the father's desertion or abandonment reported to law-enforcement officials for fear that this loss will lessen the chances of reconciliation or result in reprisal.

With the cooperation of State public-assistance agencies the Bureau of Public Assistance is now conducting a study to determine what some of the effects of the notices have been. The study will include, but is not limited to, fathers subject to the notice requirement. The study will endeavor to determine what efforts law-enforcement officials and public-assistance agencies have made to locate fathers whose whereabouts is unknown, the extent to which support orders have been issued or agreements to support made, the extent of compliance with such orders or agreements, the use of reciprocal enforcement-of-support laws, and reasons why complaints have not been filed or further action taken.

Legislators as well as staffs of public-assistance agencies are increasingly recognizing the importance of social services for families with problems that cannot be mitigated merely through the maintenance of family income. Currently the Bureau of Public Assistance and the Children's Bureau are engaged in a joint project designed to assist States in the development of more effective services for ADC families. Concern for an expanded concept of the function of public assistance is expressed in an administration bill now before the Congress which would amend the public assistance provisions of the act to make clear an intent of encouraging States to provide services to help needy individuals attain self-support or self-care.

Need for Skilled Services

The need for skilled services also exists among numerous families receiving survivor benefits. In the administration of this insurance program such services are sometimes required in selecting the payee of the benefit check when the child beneficiary has a natural or adoptive parent or close relative to care for him. Such children sometimes also need the same kind of protective services provided by child-welfare workers to children away from their parents. The Bureau of Old-Age and Survivors Insurance is concerned with sound social policy in dealing with such situations and with better coordination of the OASI program and State and community welfare services for children in determining the best means of protecting the child. Personnel in local field offices are becoming increasingly sensitive to the importance of referral to social agencies when claimants for benefits seek help with problems that income maintenance will not solve.

Despite the many limitations of aid to dependent children and child's benefits as income-maintenance services, their positive values are enormous. Through both of these programs millions of families have been enabled to remain together with the assurance of at least some income.

TWENTY YEARS OF SERVICES

(Continued from page 126)

women and girls is as prevalent as ever. Professional services are still handicapped by severe personnel shortages.

A notable nationwide study of child-health services and pediatric education made by the Academy of Pediatrics with the cooperation of the United States Public Health Service and the United States Children's Bureau, started in 1945 and completed in 1949,[1] provided much information on a State-by-State basis. Some of the conclusions were:

> "The inadequacy of financial support for pediatric education stands in sharp contrast to the funds available for medical services. . . .
>
> "Another broad generalization is inescapable. Children in outlying areas far removed from the medical centers usually found in the metropolitan areas do not receive the full benefits of modern medical care. . . . There is a time lag, and a serious one, between the newer knowledge of the medical center and its application to those living in places from which the medical center cannot be readily reached. . . . 13,000,000 children, one-third of the total child population, live in these counties.
>
> "Thus there are certain outstanding facts which emerge. . . . First and foremost is the need for more physicians who are well trained in the care of children . . .
>
> "It is equally clear that the same high quality of medical care which exists in and near the medical centers must be made available in the remote and rural areas far removed from such centers."

Yet there is another side of the picture. Divorce rates have been declining in recent years. Young families have been flocking from crowded city centers to the light, air, and grassplots of the suburbs. The tremendous surge of interest in parent-teacher activities and parent-education opportunities indicates something of the earnestness with which young couples are taking their parental responsibilities. Continuous employment opportunities have kept at bay the financial anxieties which can make for emotional tension.

During the past decade too, ever-widening vistas of scientific knowledge have continued to increase the efficacy of medical care. At the same time those concerned with the promotion of health have been broadening their concept of its meaning from a mere absence of disease to a state of positive well-being, emotional as well as physical. And, as the body of knowledge about ways of helping people with physical and emotional problems has become steadily enlarged, a sharpened realization of the importance of various skills in its application has brought about not only improved training in the professions but also an increasing trend toward teamwork among them.

These developments pose both opportunities and problems for those concerned with increasing the effectiveness of services to children. How can new knowledge such as that we now have for the control of epilepsy, the care of the deaf, the prevention of premature birth, be made available in every corner of the United States, no matter how remote? How can community interest be aroused to see that the new knowledge is applied where needed? How can more exact knowledge be obtained about the causes and cure of such complicated problems as juvenile delinquency? How can a high-standard program of foster family or special group care be made everywhere available for those who need it? What protections would be needed to prevent needless removal of children from their own homes? How can we develop adequate health and social services in local communities for mentally retarded children?

How can more young people be induced to go into the professions serving people? How can available personnel be more effectively used? How can the new interest in the emotional side of health be used to help children and young people find constructive ways of handling insecurity?

These are urgent and exciting questions with their answers hidden in knowledge yet to be achieved and in skills to be still more keenly sharpened. Just as urgent, though without the appeal of the new and adventurous, is the old, familiar question: How can we more consistently apply what we already know? In spite of the push given to better services for children during the past 20 years, cold figures betray the existence of gaping chasms of unmet need.

In the past 20 years world-shaking events have shattered the complacency of earlier years and brought stresses and strains that have deeply disturbed our individual and aggregate sense of security; but these events have also brought wonderful evidence of the staying powers of the human spirit. Their lesson for all those concerned with the well-being of children is that the greatest gift that can now be made to a child is to help him build up his potential inner strengths so that he may learn to live courageously with the anxieties history has bequeathed him.

---

[1] American Academy of Pediatrics: Report of the Committee for the Study of Child Health Services. New York: Commonwealth Fund, 1949. 270 pp.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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CHILDREN'S BUREAU STATISTICAL SERIES. Single copies available from the Children's Bureau without charge.

Diagnoses of Children Served in the Crippled Children's Program, 1952. No. 25. 1955. 30 pp.

Nationwide data by diagnostic categories of the 238,000 children who received service under State crippled children's programs in 1952 are analyzed in this report. State figures are also given for eight selected diagnostic groups.

Educational Leave in the Public Child Welfare Program, 1953. No. 26. 1955. 9 pp.

Leave of absence for study was granted to 353 employees of State or local child-welfare agencies in 44 States during the year ended August 31, 1953, according to this report. Nearly half of these became second-year students at graduate schools of social work. More than 9 out of every 10 of the persons on leave came back to work with the agency that had granted the leave.

Children Receiving Casework Services, June 1952. No. 27. 1955. 17 pp.

First of the Statistical Series to report data on services provided to children by public and voluntary child-welfare agencies, this report estimates that 400,000 children in the United States were receiving such services on June 30, 1952. Sixty-four percent were served by public agencies, 36 percent by voluntary agencies. Some 170,000 of the children were in foster-family homes, mainly boarding homes.

Juvenile Court Statistics, 1953. No. 28. 1955. 12 pp.

Delinquency cases reported by juvenile courts in 1953 increased by 13 percent over the number in 1952, says this issue, adding that 1953 was the fifth consecutive year of increase. An estimated 435,000 children (2.3 percent of the United States population aged 10 through 17) came to the attention of juvenile courts in 1953 because of delinquent behavior.

INFANT CARE. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. 8. 106 pp. 1955. 15 cents.

This is the tenth edition of Infant Care, which first came off the press in 1914. It includes a new section on the care of premature babies. Mainly because of a new layout this edition is about 40 pages shorter than the previous one and the price is therefore 5 cents less.

EVALUATION IN MENTAL HEALTH: a review of the problem of evaluating mental health activities. Report of the Subcommittee on Evaluation of Mental Health Activities, Community Services Committee, National Advisory Health Council. Department of Health, Education, and Welfare; Public Health Service, National Institutes of Health, National Institute of Mental Health. PHS Pub. 413. 1955. 292 pp. $2.

Designed to help those who seek to improve the scientific basis for mental-health programs and to evaluate their effects, this report presents an extensive annotated bibliography on theory, method, and studies in evaluation, along with observations and suggestions based on analysis of the studies. The recommendations include: that agencies involved in evaluation of a program plan early for common understanding and cooperation, and that evaluation be a continuing process; that investigators become better acquainted with studies completed and current, other than their own; that investigators undertake careful exploratory studies directed toward new hypotheses, rather than continuing to accept untested concepts as axiomatic; that the methodology and the criteria employed be improved to meet the special requirements of evaluation in mental health.

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A pediatrician trained at the Cook County and University of Illinois Hospitals at Chicago, Dr. Julius B. Richmond became a medical educator in 1946 when he joined the faculty of the University of Illinois College of Medicine. By 1951 he had become a full professor. Before going to Syracuse to take up his present position, he was for a year director of the Institute for Juvenile Research. He has served as a member of the Committee on Child Development of the National Research Council.

Since coming to Washington from Rochester, N. Y., in 1948 Dr. Reginald Lourie has set up a full-time teaching program at Children's Hospital, concerned with the application of psychiatric approaches and insights to pediatric practice. While focusing on the training of pediatric residents, the program also includes instruction and supervision of medical students from George Washington and Georgetown Universities in the hospital's well-baby clinic and wards.

Drs. Bordley, at the *left*, and Hardy, *right*, have long been interested in problems of etiology and diagnosis of hearing and related language disorders among children. Both are active clinically and in research and have pioneered in the application of special galvanic audiometry in the diagnostic measurement of hearing in infants and young children. The Department of Laryngology and Otology in the Johns Hopkins School of Medicine has been concerned with hearing and speech problems for thirty years.

A graduate of the School of Applied Social Sciences, Western Reserve University, Miss Thornhill has worked as a child-welfare specialist in the West Virginia State Department of Public Assistance and in the Community Welfare Council of Milwaukee County in Wisconsin. She has also spent a year as a Fulbright scholar in Australia studying services for unmarried mothers and adoption. On her return she accepted a special assignment with the Children's Bureau to round up the facts about unprotected adoptions and to advise on measures for protection.

An expert in the preparation of educational mental health materials, Nina Ridenour began her career as a psychologist in child-guidance clinics in Detroit and Colorado Springs. She has since served as secretary of the New York Committee on Mental Hygiene of the State Charities Aid Association, as executive of the International Committee on Mental Hygiene, and as director of education of the National Association for Mental Health. In 1948 she was one of six United States delegates to the organizing meetings of the World Federation of Mental Health.

frontispiece

FUTURE CORRESPONDENTS, or at least news readers, prepare their school newspaper.

As millions of youngsters such as these troop back to school this fall, educators and lay citizens throughout the land are preparing for the coming White House Conference on Education to be held in Washington, November 28–December 1.

The 2,000 persons expected to attend the conference—70 percent selected by State officials—will focus their attention on six major questions: What should our school accomplish? In what way can we organize our schools more efficiently and economically? What are our school building needs? How can we get enough good teachers—and keep them? How can we finance our schools—build and operate them? How can we obtain a continuing public interest in education?

What medical schools are doing to deepen the physician's understanding of patients as persons.

MEDICAL EDUCATION IN TRANSITION

JULIUS B. RICHMOND, M. D., *Professor and Chairman, Department of Pediatrics*
State University of New York, College of Medicine, Syracuse

MEDICAL EDUCATION is in transition. Dr. George Berry, dean of the Harvard Medical School, has described this transition succinctly as a shift from an emphasis on the "patient as a disease" to the "patient as a human being."[1] Dr. Alan Gregg, vice president of the Rockefeller Foundation, quoting an old French aphorism, has called this a rediscovery of the fact that "there are no diseases; there are only sick people."[2]

That considerable dissatisfaction existed with medical education on the part of medical educators and the consumers of medical care by the end of World War II has been abundantly demonstrated by the subsequent introduction of many changes in the educational process. Some of these changes will be outlined further on in this article. They came about in response to a need for new perspectives in medical education which may be understood best, perhaps, in the light of the historical development of the modern medical school.

As we know it today the medical school is a relatively new institution. At the turn of the century the major part of medical education was provided by numerous proprietary schools scattered throughout the country. Although the trend toward a 4-year curriculum was already underway, the publication of the Flexner report[3] in 1910 accelerated the movement. Consequently, many schools were brought into the fold of universities, a standardizing agency—the Council on Medical Education of the American Medical Association—came into being, and the proprietary schools gradually disappeared. The licensing boards of the various States also sped up this trend.

Along with the building up of the 4-year curriculum rapid advances in the biological and medical sciences were taking place. Accepting their full responsibilities to society and to their university identification, medical schools not only carried out their teaching functions, but also turned themselves into strong research centers. The developments which emerged are now common knowledge. The prolongation of life, the reductions in maternal and infant mortality, the decline of child mortality from infectious and nutritional disorders are but part of the rich harvest of this era.

Because of the relatively uneven development of medical schools, the first half of the 20th century was characterized by an emphasis on raising standards and incorporating new scientific knowledge within the 4-year curriculum. The rapid advances in knowledge presented a real problem, for more content kept being added to the curriculum with each passing year while other subject matter rarely was deleted. Difficult though this was for faculties, it was even more rigorous for the student. Upon one point there seemed to be general agreement: medical students had attained a degree of technical competence never before achieved.

The Criticisms

The major disruptions in medical education and practice associated with World War II and the increasing expectations from medical practitioners on the part of the community stimulated a reevaluation of medical education. This brought forth the following general criticisms:

1. ***Teaching is too compartmentalized.*** The student

is taught by groups of specialists, preclinical or clinical. He has too little opportunity to observe the patient as a whole or to observe faculty members who present an approach to the total patient.

2. *The student is not brought into contact with patients* during the first 2 years of the medical school curriculum. The strong motivation with which many students enter upon the study of medicine is therefore unexploited during the first 2 years.

3. *Content about the impact of social and psychologic forces on the individual has generally not been adequate* to prepare the student fully for a constructive role in the community on entering practice. When such teaching has been attempted, it has tended to be too didactic to be meaningful to the student; the clinical setting has been used inadequately. An opportunity for the student to develop a background for his own social thinking and insight into his own personality development has been lacking generally.

4. *Insufficient emphasis has been put on preventive medicine and the maintenance of health.* The doctor's role in developing a positive health program for our population should complement his concern with the study of disease.

Meeting the Problems

During the past several years, medical schools individually and collectively have been attempting to deal with these problems. The American Medical Association and the Association of American Medical Colleges have jointly sponsored an elaborate survey of medical education, which has now been completed.[4,5] The American Academy of Pediatrics has sponsored a study of pediatric education followed by annual conferences on educational problems.[6] The Association of American Medical Colleges and the American Psychiatric Association have jointly sponsored a conference on psychiatry and medical education.[7] The Association of American Medical Colleges has supported a conference of professors of preventive medicine.[2] Annual teaching institutes concerned with curriculum problems and teaching methods among the various departments of medical schools are currently under way. Conferences on premedical education and on administrative medicine have also been held. The congresses on medical education and licensure sponsored by the American Medical Association and the annual meetings of the American Associaion of Medical Colleges have provided opportunities for the exchange of ideas on educational planning.

Individual medical-school faculties have been vigorous in reorganizing and reintegrating their curricula. Thus while the first half of the 20th century brought about a traditional and relatively static curriculum, the second half promises to be one of increasing flexibility and experimentation. However, the experimentation which is now under way is generally characterized by a healthy maturity and skepticism. In general a real effort has been made to build into these programs opportunities for evaluation of their effectiveness, difficult though any evaluation of an educational process may be.

Lest there be any concern about possible loss in the teaching of scientific medicine it is important to emphasize that the gains which have been made in this area are being carefully protected. There is no desire to have the physician less well equipped scientifically than he has been in recent years. However, some of the new flexibility can be attributed in part to the increasing realization that undergraduate medical education is no longer the terminal education of the physician. Graduates generally proceed with at least 1 year of internship while increasing numbers pursue specialty training for an additional 3 or more years. Thus the undergraduate medical curriculum is only a segment of the training of physicians today. It is folly, therefore, to add information increasingly to the curriculum without reevaluating content with the objective of providing the student with a body of knowledge which his cerebral cortex can realistically deal with and absorb.

New Programs

In order to attempt to prepare the modern physician for his social responsibilities to the community and to deepen his understanding of the patient as a person, a variety of programs are in progress—more than can be described in the space of this article. In one instance these efforts have involved a thoroughgoing reorganization of the curriculum of the medical school. In other instances the attempt has been to introduce new courses within the conventional 4-year curriculum. In general these programs may be summarized as follows:

1. *A complete reorganization of the medical-school curriculum,* as exemplified by the program at the School of Medicine of Western Reserve University. In this program curriculum reorganization has resulted in integrated teaching of the conventional subject matter. The faculty has bridged the traditional departmental compartments to present to the student a view of human biology whole. Thus structural, biochemical, and physiological relationships are

taught concomitantly according to an interdepartmental plan by faculty members without regard to their departmental affiliations. As a consequence of this curricular reorganization, considerable revision of the physical plant of the medical school has been necessary, since the student studies in a laboratory of his own rather than in a sequence of departmental laboratories.

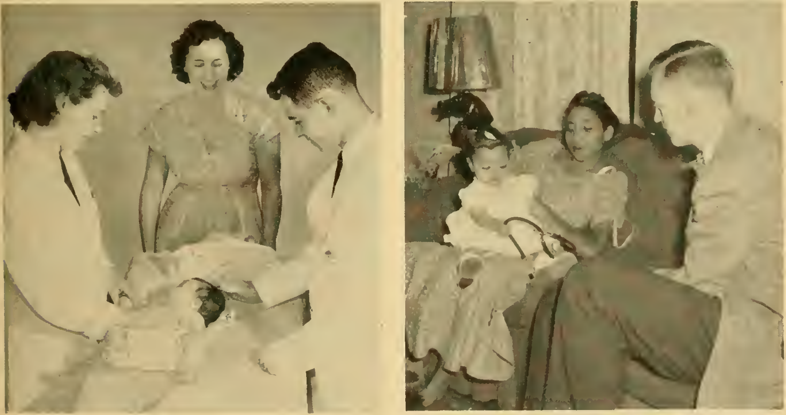
The student early in his freshman year begins to work with a family, focusing on the care of a baby. His contact with the family starts in the prenatal period and carries through and after delivery. Guided by a preceptor, his relationship with the family continues over the 4 years of medical school. He learns the role of social workers and other personnel with whom the physician works in planning for the care of patients in the community. Thus an opportunity is provided at the outset for him to develop relationships with patients and to utilize the motivation which presumably brought him to the medical school.

In such a program a strong commitment on the part of the faculty to such a complete reorganization of curriculum and teaching methods is essential for success. Other medical schools have not yet undertaken such complete revision, but the program is being observed with considerable interest and enthusiasm by medical educators today.

2. Home care programs. Several medical schools in the United States have for a number of years had programs centering around the care of patients in their own homes. Through them students are provided an opportunity to see patients in their social and cultural settings and community relationships and to develop a greater appreciation of the problems associated with their medical care.

The effectiveness of such programs is generally related to the time available and the skill and interest of the teaching faculty. Unfortunately because of the fact that students are often assigned to these programs for short periods of time, usually in the junior and senior years, they have little opportunity to observe continuity of care and to develop the deeper insights into patients' problems which come from repeated contact.

3. Outpatient programs designed to provide continuing experiences with patients. The Cornell and Colorado Medical Schools have attempted to assign fourth-year students to extended periods in the outpatient departments and to provide them with a general assortment of patients in order that they may have continuing experiences in providing com-



Two phases of Western Reserve University's revised program of medical education. *Left,* a student in the first phase, which concentrates on developing an understanding of the normal, watches a woman pediatrician in a well-baby clinic examine a child as the mother looks on. *Right,* a student of phase 2, which concentrates on a correlated study of the abnormal, visits a patient in the home. In phase 3, a program of comprehensive care of patients in the home will provide the student with continuity of observation, and will be integrated with his laboratory and scientific studies.

prehensive care. This contrasts with the traditional system of rotation through the usual specialty clinics of the medical school. The student has an opportunity to experience the same medical problems which he would ordinarily see in specialty clinics, but at the same time to develop a continuing relationship through which he can deepen his insights into the social, cultural, and personality patterns of the individual and the family. This type of program involves considerable reorganization of outpatient facilities and reorientation of staff. In general, additional staff is also desirable.

Because of the increasing interest in prepayment medical plans, group practice, and labor health plans, such settings are also being utilized for the teaching of comprehensive medical care. They make it possible to place a heavy emphasis on preventive health services, which conventional outpatient facilities often do not provide.

4. ***Family-study programs.*** Some medical schools have developed programs providing for long-term study of a sampling of families. Although some of these programs have been established primarily for research into the medical, social, and psychological aspects of family life, students are increasingly being integrated into them. Many programs of this type provide an opportunity for exposure to disciplines as varied as microbiology, immunology, epidemiology, cultural anthropology, social work, psychology, sociology, and the various medical specialties. Some of them focus on providing medical care for a specific member of the family. The care of well babies has been a popular way to give students an opportunity to view family life and its impact on infant and child care. Departments of preventive medicine and pediatrics have been particularly active in supervising such teaching.

5. ***Programs centering around an understanding of the medical-social problems of the patient.*** In some medical schools the student is introduced during his first year to the problems which families experience in obtaining and utilizing medical care. Some of these programs, as at the University of Pennsylvania Medical School, have continuity through the 4 years of the medical school; in other instances they are limited to a single year. In these programs the student obtains information from families concerning their medical problems, occupational health problems, and their feelings about the medical care which they are receiving. The students' observations about the family and its degree of integration within the community are discussed in seminars with physicians and social workers. In some schools sociologists, cultural anthropologists, and psychologists have also been drawn into these programs.

6. ***Earlier introduction of the teaching of psychiatry.*** In the last decade medical schools generally have introduced psychiatry into all 4 years of their curricula. Although in many instances such teaching in the first 2 years is didactic, it has nevertheless provided students with some knowledge of the behavioral sciences, thus better preparing them to deal with patients clinically. More effective, perhaps, is the utilization of a clinical setting for such teaching, a practice which is gradually becoming more common. In whatever setting, courses in psychiatry also help the student develop deeper insight into his own feelings and attitudes.[8]

7. ***Courses in human development and human biology.*** Some schools have attempted to provide students with a better understanding of the total development of man through a dynamic presentation of human growth and development in physical, intellectual, psychologic, and social terms. These courses may be didactic presentations which are largely interdisciplinary and interdepartmental in nature, or they may center around a longitudinal growth study program such as that of the Child Research Council, University of Colorado School of Medicine, in Denver, or in some instances around the observation of the growth and development of an individual baby and family, as in the previously mentioned family-study programs.

8. ***The introduction of psychology, sociology, and cultural anthropology into the curriculum.*** Many medical educators have felt for some time that students will learn more about the social, psychological, and cultural background of people if persons with highly specialized backgrounds in these fields are added to the faculties of medical schools. Therefore we are increasingly observing the addition of sociologists, psychologists, and cultural anthropologists to medical-school faculties. Their roles vary considerably from school to school, ranging from participation in research projects to the conducting of individual courses. Perhaps the major significance of this development has been the availability of these uniquely oriented faculty members to the remainder of the faculty.

An interesting sidelight to the development of these programs is the interest in evaluating their effectiveness. Although in years past attempts at evaluation of educational processes were regarded as rather futile, research advances in the fields of sociology and psychology render such undertakings more feasible today. Current experimentation in evaluations seems to have a favorable effect on the educational processes and, hopefully, may provide objective measurement of whether programs are really accomplishing what they have been set up to achieve. Evaluation processes, however, are laborious and expensive and are still highly experimental.

Some Words of Caution

Although the latter half of this century seems destined to be marked by experimentation in medical education, some words of caution are in order. It would be unfortunate if the idea became prevalent that change in educational process can be accomplished by a mechanical reorganization of curriculum or by transplanting courses which have proven effective at other schools. In the last analysis, what and how a student is taught reflects the orientation of his entire faculty. The effective teaching of the social and psychological aspects of patient care is a goal for which the entire faculty must assume some responsibility. Fortunately, a core of medical educators exists who are excited about the possibility of giving students a broader orientation.

No matter how well integrated the faculty, however, the integration of medical knowledge and of social and psychological understanding of patients must ultimately be accomplished by the student individually. Therefore, in addition to a broadened curriculum, the personality and intellectual ability of the student are important factors. This means that problems of student selection emerge as primary in this whole process.

Unfortunately little is known concerning medical-student selection although each school is attempting to study the problem in its own way. Considerable concern exists about the effects of the increasing cost of medical education in discriminating against prospective students from the lower-income portions of our population.[9]

Another note of caution is in order. As has been indicated herein, during the course of his medical-school career the student is increasingly being shown by example the effectiveness of comprehensive care for patients. Consequently, the medical-school program tends to present a somewhat idealized demonstration of community resources and available personnel. This picture is often not entirely in accord with the realities of professional practice for in most communities available facilities are not comparable to the medical-school setting. To obviate feelings of disillusion and despair when the student enters practice, it becomes important that the faculty help him to learn to deal with limited goals. At the same time he should be prepared to aid in the community's planning to provide more adequate services.

Medical-school programs such as have been described here are becoming more and more costly. No longer can the schools depend solely upon individual practioners in the community to carry on the instruction involved. As a consequence they have been steadily enlarging the size of their full-time faculties. If the community desires to have more effective physicians, it will of necessity have to find a means of supporting these enlarged programs. A prerequisite for obtaining the needed faculty members is support for potential faculty members during their extended periods of training. This is increasingly being provided through grants from public agencies, from private foundations, and from fund-raising efforts for medical schools.

Out of the newer developments in medical education more effective health services to our Nation should become available without sacrifice of the rich tradition of our medical schools. In the words of Dean Berry, "Scientific medicine must become comprehensive medicine, yet not become thereby any less scientific." [1]

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The common sense of doctors, nurses, and other health workers can make a difference in . . . .

DELINQUENCY PREVENTION — A HEALTH WORKER'S JOB, TOO

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IT IS GENERALLY AGREED that what this country needs is a good common-sense solution to the problem of juvenile delinquency. However, some common sense is being applied to the problem every day in almost every community, while the incidence of juvenile delinquency keeps on growing. What seems to be lacking is the concerted use of all the kinds of common sense available. If the common sense of doctors, nurses, and others in the health field were added to that supplied by the legal, law-enforcement, welfare, sociological, educational, and law-making facets of the community perhaps the efforts would have a better chance of working. The health field has a body of information available, particularly about the structure of the brain and personality and about the interaction between the body, mind, and environment, that can bring all common-sense approaches to delinquency closer to realities.

Our experience shows that in the first 5 or 6 years of life the basic elements of personality are established. We also are aware of many of the elements that can go wrong and distort the resultant personality. This information must be made an integral part of the professional equipment of all people trained in health work if they are, in their distinctive ways, to apply it in their everyday dealings with children who act out personality distortions. Trying to deal with delinquency without this knowledge and skill is like bringing a car to a garage because it does not run right and having the repair people clean the windshield, straighten the fender, fix the tires, but never lift up the hood because they have never been trained to know what is under it and what they can do with this to effect minor or emergency repairs. Thus, we need to bring not only into schools of medicine and education but also into schools of nursing and health education and into the training of the technical aspect of health services, teaching about personality development, the principles of interviewing and those involved in therapeutic approaches to people's problems, as well as knowledge of community resources and how to reach them.

True, some professional persons are fearful of bringing this content into teaching, particularly when they interpret it as creating a tremendous army of therapists rather than as spreading information. They forget that most people in trouble do not turn to the specialized mental-health services but rather to the rank and file of health workers. Have these unspecialized workers any right to deal with personal problems? This is an academic question not only because of the dearth of specialized services in most areas but also because health workers are dealing with such problems all the time. They are forced into this position by the people themselves and by courts, schools, institutions, and social agencies, which frequently ask them to participate in the care and disposition of children already in trouble. Therefore teaching health personnel something about what goes into normal and abnormal mental functioning would give a better guarantee as to the kind of help they would provide. What is needed is an army composed: first of all of casefinders; second, of persons qualified to deal with a large number of problems that normally arise in regard to children; third, of persons who can provide emergency assistance or consultation for serious difficulties; and fourth, of knowledgeable persons who would be in a position to apply preventive techniques.

Casefinding

First comes casefinding. Health workers of all kinds are in a position to see problems that might otherwise be overlooked. When a person lets down part of his defensive armor with those who take care of his physical difficulties—taking off clothes may be the first step in this—it becomes easier and even natural for him to talk about other difficulties. This is when it is important to recognize what he reveals. If the health worker knows how emotional difficulties are rooted in unsolved phases of personality development and how physical handicaps and brain damage influence the ability to solve fundamental problems in relationship or to obtain satisfaction from living he will be able to explore these areas of functioning in the course of his other services. Otherwise they might never be explored until the patient gets into trouble in the community and forces the community to do something about it.

Frequently a simple question about adjustment in school, or to siblings, or to parents, or to social life—directed to the school, or to the parents or the child, or both—opens doors that people did not realize could be opened or elicits such responses as "I didn't know you cared about this." On the other hand, the response may be: "It isn't any of your business" or "There isn't any trouble at all" when trouble very evidently exists. At such a point a well-prepared health worker need not feel luckless or frustrated. With interviewing skills at his command, he can keep the subject open instead of having the door closed in his face.

The health worker needs to know something of personality structure and interpersonal communication to be helpful not just to the person or the family asking for help and able to use it, but also to those who do not see the need for help or who cannot accept it after they ask for it. He needs to know enough to recognize when people—adults or children—are unable to relate to others, are unsure or frightened, disorganized, and asocial and how these patterns affect those about them as well as themselves. He needs to know what is symptomatic about the predominant use of denial, passing the blame onto others, withdrawing and avoiding, or guilt-burdened overprotection. He needs to know how to avoid getting involved personally with the people he is trying to help or feeling personally hurt or rebuffed by rejection of proffered help. He needs to know how his patients handle their emotional problems in the same way he knows about their handling of physical problems.

In whatever setting the health services are being offered, whether it is in the plant, the office, the school, the home, health workers need to keep their eyes and ears open—and might have to open their mouths—in order to stop the kind of difficulties that could lead to disturbed behavior. We do not have enough knowledge at this point to be able to predict definitely when emotional disturbance will end in acting out or in overt delinquent behavior, so that we need to think of dealing with any and all forms of deviant behavior and adjustment if we are to make advances in spotting the potential or early delinquent.

Provision of Services

The next two points must be considered together—the provision of services to those we should be able to help without any outside assistance, and of emergency services to those who need more continuous or specialized help.

To understand better what the role of the health worker can be in such instances we should take a look at what the sources of problems in children are. A good working etiological classification, although by no means complete, finds them stemming from five areas:

1. Faulty training.
2. Surface conflicts, as with parents and siblings and in the social, learning, and sexual aspects of functioning.
3. Deep conflicts (neuroses).
4. Physical difficulties, including handicaps, brain damage, metabolic disturbances and poorly handled convalescence.
5. Mental difficulties, including psychoses and mental deficiency.

The first two groups account for 80 percent of all the problems children present. This means that the vast majority of children's problems do not require the mental hygiene team's approach nor specialized psychiatric care. In four-fifths of all the emotional disturbances that health workers encounter the roots are shallow and are easily dug out. To get at them, however, it is necessary to spot the etiology of the problem, since the symptoms are relatively nonspecific and are different with different individuals. For this the health worker can use as a frame of reference the current body of information on normal personality development and on where and how the snags in it develop. Then, after talking with and observing the patient, common-sense answers as to the corrective procedures called for will usually be forthcoming. This approach is available to the general practitioner, the pediatrician, the clinic, the hospital and school nurse, as well as to many others. In other words, if we lift the hood of the car, we find that there are many things that health workers are competent to handle short of taking apart the more complicated parts such as the carburetor or the engine itself.

Sometimes, however, the symptoms themselves do not reveal whether the disturbance is superficial or deep-seated. Even then the health worker should try his corrective surface approaches in order to find out whether the specialist's deeper probing into the engine is necessary. Contrary to some opinion, this topical application of knowledge will not harm most persons whose difficulties are too deeply rooted to be affected by it. Enlightened health workers have a better chance of being right than the neighbors, than Grandma, than the mother-in-law, than the storekeeper, who usually have already offered some kind of advice by the time the problem comes to the health worker's attention.

Health workers are often in a position to spot incipient personality problems, for a young person's defensive armour often breaks down with those who take care of him physically.

When faced with acute flareups in their clinical contact with families health workers confront many practical difficulties. The easiest out is to make a referral, but this is not always possible. There may be no mental-hygiene clinic in the community, or if there is, it is likely to have a waiting list 6 months long and a heavy load of "emergency" cases, making even an "intake interview" an impossibility in less than a week.

In acute flareups, however, a family needs help immediately in handling the child who is running away, or setting fires, or has been caught in an asocial activity that has aroused the neighborhood, the school, or the parents into a call for action. The anxiety engendered at such times is acute, and it is often this anxiety, with its resulting changes in homeostatic balance, that makes it possible for people to seek or accept help.

We learned some lessons about this in the combat areas in the last two wars. When a soldier became acutely anxious or distressed on the front lines in Korea, if possible he was interviewed right behind the lines, allowed to sound off about such things as his fears, his worries and all the injustices, past and present, to which he had been exposed. Then he was reassured, rested and reassigned and an awareness created in his environment about some of his needs and about the things he could properly avoid. He usually was then able to get to the front lines again as a participating soldier. However, if he was sent back from the front to the field hospital, to the base hospital and eventually to the general hospital, the chance of his functioning again as a useful soldier became slimmer and slimmer. In other words, in emotional disturbances, it is when the pain is acute that we can often be of greatest assistance, particularly in keeping a family or an individual from withdrawing further, becoming more hostile and vengeful, accepting new ways of functioning with others or reacting with more strife or disorganization.

What can we validly do at such points? There is a widespread opinion that the only valid approaches are those of the psychiatrist and of the psychiatric clinic and that their techniques are sacrosanct. However, as we look over the evolution of our philosophies of treatment, we see that we have gone through a number of phases, starting with doing something *about* children in trouble, going on to doing something *for* them and finally to doing something directly *with* them. Perhaps there are still plenty of things that can be done *about* and *for* a family in acute trouble. Environmental deficiencies can be modified, deprivation corrected, trust established or reestablished, resentments aired, physical handicaps dealt with. Community resources can be mobilized.

Moreover, there are levels of working with patients that can be therapeutic without becoming profound involvements. Since the basic element in most forms of therapy is the relationship between the patient and the therapist, the resultant corrective emotional experience can be an integral part of the emergency services that health workers are in a position to offer. It can be like dealing with a very painful abscess by making an adequate incision that allows the pus to erupt and drain or, if there has been a spontaneous rupture, making sure that it does not wall over again and remain a constant irritant. At the same time we can look for the kind of long-term assistance that can provide more direct working with family members. Unlike the surgical emergency, the personal crisis may go on for days and weeks but mistakes in dealing with it are not nearly so costly as in surgery for they are rarely fatal.

We will always find persons who refuse help even for abscesses. This calls for reevaluation of the health worker's policy of waiting for patients to seek their services—especially when the pathology involves the community. In social work a new kind of aggressive, "foot-in-the-door" type of casework is evolving. Even if a whole family cannot be reached, finding one individual in it who can be worked with may be worthwhile. It may be necessary to deal with the child even if the parents will not participate. Children can be helped to achieve an amazing degree of tolerance about the people and conditions around them.

That such emergency measures can be effective and can be used on a large scale has been demonstrated by Rosenfeld and Caplan in Israel.[1]

Practical Difficulties

Health workers need to reassess their skills and knowledge to see how the personnel available can fit into the provision of such services. The greatest hazard to providing this kind of on-the-spot help are the health workers themselves. They may be too busy or afraid to use psychiatric techniques, or they may be people who cannot listen, who have to tell people what to do, or who themselves find it hard to relate to others. One of the greatest drawbacks is represented by those workers who do not believe in mental mechanisms or merely give lip service to body-mind concepts.

Health workers with interviewing skills and knowledge of personality development can lessen parents' worry about normal paradoxes in child behavior, alert them to incipient trouble, and help them accept referral when necessary.

A perennial question among the doubters is where to find the time to fit such procedures into full daily schedules. It is true that a busy doctor or nurse cannot take a half hour or an hour to ask questions and think through the evidence at hand, especially when the waiting room is becoming a bedlam and time for lunch or outside calls is running short. True, too, this cannot be done in a routine 15- or 20-minute office or clinic visit. However, numerous ways have been worked out for having a more concentrated block of time available, such as setting aside an hour a week for consideration of an emotional problem or another health problem that requires more than routine time. This practice can actually be a time-saver. Think of the number of 15-minute sessions devoted over a year to an effort to break down a stubborn habit problem about which a lot could be learned in a single long session.

The idea that personality distortion might be prevented goes back in this country to the pioneers in American psychiatry. With each step forward in our knowledge has come the hope that a new preventive method has been found. With each failure in application of our knowledge has come a wave of pessimism about the possible effectiveness of preventive efforts. We are currently in a phase of optimism because our present insights into mental functioning are proving more and more valid for spotting the kinds of parent-child interaction that are known to lead to distortions in personality development.

This interaction starts with the attitude of the mother to her unborn baby. There are all kinds of people in the world and most of them have children. There are psychopathic, psychotic, immature, and unrealistic parents as well as those with neurotic attitudes about such things as feeding, affection, cleanliness, and constipation. Thus, what has come to be somewhat euphemistically called anticipatory guidance needs to be concerned not only with the forms and practices that have to do with the rearing of children but also with the feelings involved.

Health personnel must be trained to listen not only to the words but also to the music of what goes on in the families that they deal with. It is not enough for them to provide intellectual approaches to the expectant crises that stages of personality development bring. For example, we have learned a great deal about what can go wrong with the feeding processes. As a result, in many areas well-baby clinics are reporting few of the formerly prevalent feeding problems. However, they report many more sleeping problems. We have also found that changing the forms of toilet training from the early rigid practices to more relaxed, more logically timed approaches does not change the incidence of anal character traits. The more subtle identifications with parental personality attitudes and responses cannot be influenced simply by changing outward forms. The normal fears, such as separation and bodily hurt, will still be difficult for a child to deal with if his responses to them cause anxiety in a parent. Thus, health workers need to know, whenever possible, something about the parents to whom they are giving advice, so that they will tend less to deal with them as stereotypes and will take into account their individual constitutional makeup, along with organic elements and the environment.

Education and Research

To achieve this we need to turn to our professional schools and think in terms of teaching procedures and supervision calculated to provide awareness of self and others, such as has been demonstrated as feasible in schools of social work and is creeping into the medical schools and schools of public-health nursing. We might also reexamine the values of our educational approaches for corrective as well as preventive efforts.

An element that is often overlooked in preventive efforts is the importance of continuity. This means followup by health personnel not only from the prenatal through the preschool years but also through the grammar- and high-school years. The sharing of information by health personnel with welfare, school, and law-enforcement agencies is also an important factor in allowing these agencies to proceed in an enlightened manner with children in trouble.

While we have a long way to go to spread the information we now know about personality development and the ways in which it becomes distorted, we are also a long way from knowing all we need to know—especially about the developing ego and how it deals with the aggressive drives, the nuclear problem in understanding and dealing with juvenile delinquency. Research, then, must take a top place in our preventive efforts.

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[1] Rosenfeld, Jona Michael, and Caplan, Gerald: Techniques of staff consultation in an immigrant children's organization in Israel. American Journal of Orthopsychiatry, 24: 42–58, January 1954.

Any person who tries to help another should establish *rapport.* Through training, experience and self-criticism, the psychologist or social worker learns to reduce fear and shame. He must really like people and believe in them. In his heart of hearts, he knows that successful persons achieve their status through a combination of events for which they can claim only partial credit. He knows that countless families live close to the margin, close to humiliating forms of poverty, neglect and social ostracism. He knows that skin color, nationality, inheritance, poor health and poor education may leave their mark upon a child long before there is a chance to make good as a *person.*

—George D. Stoddard, New York University, at the 1954 Forum of the National Conference of Social Work.

Veteran hearing-aid users under 6 prove the great social and emotional gains that come from . . .

TREATING YOUNG CHILDREN FOR HEARING IMPAIRMENT

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THE CHILD WITH IMPAIRED HEARING presents a special challenge in diagnosis and treatment, and, when disability is permanent, in development and training. Because of the close relationship between impaired hearing and behavior, the earliest possible diagnosis is indicated. Hearing disability inevitably promotes deviant behavior, with varying consequences to the individual's welfare.

The etiologic pattern is diffuse. The great majority of infants and young children with hearing handicaps suffer from injuries to the auditory nerve, or central damage, rather than from the middle-ear conditions resulting from upper-respiratory infection, common in school-age children. In the past 5 years approximately 2,000 children under 6 with hearing difficulty have been examined in the Hearing and Speech Center of the Johns Hopkins Hospital. In a small number of them the impairment is clearly assignable to familial traits; in a large number it belongs in the category of undeterminable etiology. Some of the latter have had no contributory medical histories, while others have had such agglomerate histories that precise determination of cause is impossible. The remainder, about 75 percent of all, can be subsumed etiologically as:

1. Ultra-virus infection of the mother in the first trimester of pregnancy—the causal factor in a high percentage of hearing impairment among young children.
2. Prolonged or severe anoxia at birth.
3. Birth injuries and prolonged labor with instrumentation.
4. Erythroblastosis, an anemia connected with Rh incompatibility of mother and fetus. This is a prevalent factor in auditory impairment among athetoid children.
5. Severe viral infections in the first 6 to 8 months after birth, damaging to the hearing structures.
6. Meningitis, particularly influenzal meningitis of the very young.

Types of Impairment

The incidence of hearing impairment or relatable language dysfunction among preschool children is rapidly rising. This may be attributable to the fact that modern obstetrics and pediatrics are saving more and more defective children who formerly might not have survived. All the classical types of hearing impairment have been found among this age group but the proportion of pure conductive lesions is small.

Nerve-type or perceptive impairments are caused by atrophy or underdevelopment of the cochlear nerve, or organ-of-Corti cells, in the inner ear, or to lesions somewhere along the central auditory pathways. High tones are commonly more affected than low tones. However, when the hearing loss is severe, whatever the cause, both high and low tones are involved. The effect is not only of lessened intensity but also of acoustic distortion so that understanding as well as hearing is impaired.

In general, no adequately demonstrated treatment for perceptive impairment exists. However, total

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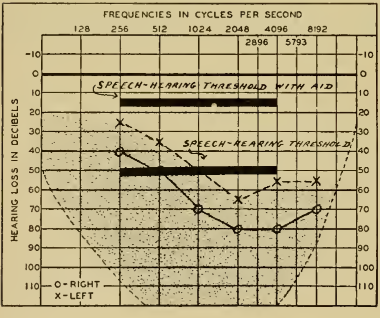
nerve-type deafness is extremely rare in this age of early diagnosis and advanced chemotherapy. The fact that a child does not appear to respond to the ordinary limits of sound does not mean total impairment. It is a rare child, indeed, who does not have some residual hearing. The determination of how much is a matter for clinical testing.

Conductive impairment results from interference with the mechanics of audition in the external canal or in the middle ear. The effect is the dampening of the transmission system, thus diminishing the intensity of sound. While this never results in total deafness, it may cause great difficulty in communication. Children with conductive impairment are apt to live in a world of "muddy" sound wherein clear distinctions are difficult to make, thus hampering their ability to pay attention. In the very young child this penalty is particularly severe and commonly causes considerable retardation in both language development and social maturity. In many children with conductive impairment, hearing, and therefore behavior, fluctuates greatly, to the confusion of their families.

Conductive-type hearing impairment in a very young child is usually amenable to treatment, when diagnosis and followup action are promptly undertaken. A conductive-type impairment involving midline adenoid tissue and obstruction of the Eustachian tubes often complicates a basic nerve-type impairment. This can be relieved by medical and surgical therapy, to achieve a permanent baseline of hearing.

A psychogenic hearing impairment also exists which presents no symptoms of otic pathology but affects normal functioning. By no means rare in children, this usually presents a difficult diagnostic problem.

Figure 1.



Another problem evidently rapidly increasing in incidence is only apparently one of hearing. A child fails to respond to sound although he has a normal hearing end-organ. The core of the problem is at a higher level, in the cerebrum, and involves not the reception but the perception of sound. Sound penetrates to the brain, but lesions there or developmental lacks prevent a normal association of it with meanings and therefore interfere seriously with the development of appropriate responses and of the structure of the verbal symbolism called language.

Hearing Evaluation

Evaluation of a small child's hearing acuity and potential is not a simple process. It requires a careful case history with special attention to prenatal and natal events which could be causal factors, the time parents suspected a hearing loss, possible contributory data in postnatal history, and the degree of normality in the child's physical and social development as well as a careful study of his reactions to sound, including direct observation of the child and inquiry of the parents. It also involves careful observation of the child's play activity, his adaptation to new situations, his motor development, attention span, and social maturity.

Otherwise normal children with impaired hearing soon become highly visually-oriented; by the age of 24 to 30 months they will have developed an extensive gesture language. Those with a fair amount of residual hearing will be using their voices quite consistently in babble and will have made definite attempts to communicate verbally. Very deaf children will not continue to babble freely, for they cannot monitor their own vocal attempts well enough. Those with central disorders, wherein the trouble lies in the cerebrum rather than in the end-organ, will commonly ignore sound or respond only sporadically.

A thorough diagnostic work-up involves a complete otorhinologic examination, including careful inspection with a nasopharyngoscope. Important, too, is careful pure-tone audiometry. A difficult procedure with most young children with impaired hearing, this usually requires the services and facilities of a special clinical center. However, general physician can find out a lot about a child's hearing provided that the sounds he uses for testing are of known values of intensity and pitch.

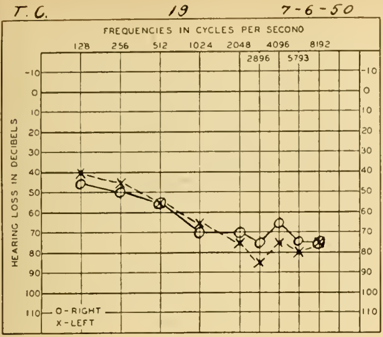


Figure 2.

The early detection of hearing impairment in young children depends largely on the astuteness of the pediatrician and the general practitioner in interpreting the developmental history and in observing the degree of language development.

A child talks because he hears and as he hears. Gradually, with much imitation and reiteration, he begins to relate sounds to meanings and to develop language comprehension; only then does he start to talk. If the child's hearing is severely impaired, ordinary sound is meaningless to him; very loud sound will capture his attention but will not continue to do so until and unless it becomes a daily, hourly experience. If he has a moderate-to-severe impairment, with fairly good residual hearing for low-pitched sounds, he will respond to a variety of sounds if paying attention to them is worth while.

Some children, with severe acoustic distortion—good acuity for low pitches but rapid deterioration as pitch increases—learn very soon to ignore sound. Hearing something of everything but not enough of anything, they have little opportunity to learn to discriminate between father's voice and mother's voice, or the telephone bell and the tinkle of the Good Humor man. In a world wherein most sound is very much alike, they will stop making the unrewarding effort toward an impossible differentiation. Consequently, many are mistaken as mental defectives.

A similar sequence may be implicit in the behavior of the brain-damaged or cerebrally maldeveloped child. In him sound penetrates the analytical structure of the end-organ but is not translated readily into meaning at the cerebral associative levels of differentiation and recall. Thus the development of normal language symbolism is blocked. These children need special training which is very different from the kind needed by the deaf child.

In plain terms, children with severe hearing impairment do not develop naturally as do their peers with normal hearing. Lacking a fundamental component of the natural means to communicate, they find learning a slow and complicated process. Moreover, many of those who come to clinical attention present a combination of defects—auditory, intellectual, and psychological. The diagnostic problem frequently resolves itself into a determination of whether hearing impairment plays any part in the deviant development.

Between the ages of 2 and 6 years children are highly absorptive and responsive and at their peak as natural language-learning mechanisms. Therefore, medical or surgical measures to correct hearing loss should be carried out as early as possible. Children with permanently impaired hearing must have a careful evaluation of its degree and the relation of this to general development and behavior, so that plans can be made for habilitation or rehabilitation.

Few children are totally deaf; most can gain some material benefit from the use of a wearable hearing aid. Once the picture of the child's hearing loss and potential is obtained, effort should be made to put his residual hearing to use as an adjunct in learning language. For children with profound hearing defect, vision must be the basic stimulus, with audition an adjunct. For those with a relatively large amount of residual hearing (down to about 65 decibels below normal), audition can be basic, as it is normally, with vision adjunctive in language learning. Many children whose hearing impairment is moderate or severe can be brought to normal functioning with training and the use of a hearing aid.

A Communicative Dysfunction

Deafness is a dysfunction not only of the ears but of the listening mind. Many children with quite good potential levels of auditory acuity become functionally deaf because they have never had the opportunity to learn to hear. A recent diagnostic analysis of 572 preschool-age children suspected of hearing impairment because they did not develop normal language and speech, revealed that 116 had normal auditory end-organs. Their developmental lacks were caused by a variety of factors, from mental deficiency to behavioral pressures. In this study speech-hearing potentials were generalized from pure-tone audiograms obtained by a special measuring technique, galvanic skin-resistance audiometry. In this procedure a very young child responds to sound with an involuntary reflex.

Over 2,000 preschool-age children with hearing difficulty have been tested by skin-resistance audiometry in the past 5 years. Only 27 percent were found to be profoundly deaf. Apparently only about 30 percent of educable children with hearing impairment are educatively deaf, that is, require special residential or day-school training.

All children with handicapping hearing impairment require special help at both preschool and school ages; how much and what kind depends on the child's particular needs and capacities. Those with mild or moderate impairment are well within reach of a wearable hearing aid and, other things being equal, can be expected to function within normal hearing range. Those with severe impairment require a great deal of careful analysis and special help. Whether eventually they will emerge as "hard-of-hearing" or as "deaf" children depends largely on the way they are handled and how society helps them meet their problems.

The 2-year-old with a severe hearing impairment does not belong in school; he is not yet ready to learn in any formal regimen of teaching. Once the clinical picture is clear, his parents must be taught every possible insight into his needs and ways to meet them, how to help him discriminate between sounds and to learn language, usually with the constant use of a wearable hearing aid, and eventually to develop understandable speech. This as well as the determination of hearing loss and potential is an important aspect of clinical audiology.

Some Case Histories

The following cases illustrate the importance of early case finding.

Figure 1 shows the audiogram of a 6-year-old whose hearing impairment was caused by toxemia in her mother during pregnancy. When she was first seen at the clinic at the age of 2 her hearing for tones below 1,000 cycles was much less than this audiogram shows. After retest was done by galvanic audiometry she was fitted with a wearable hearing aid at the age of 26 months. She developed language and speech well. The dark lines are actual threshold measurements of her speech-hearing ability. With her hearing aid, she functions well within normal range. Now 7 years old, she is in a regular second grade at school and is leading a normal life.

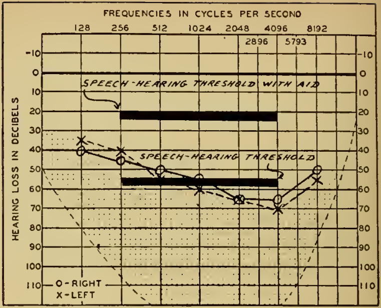


Figure 3.

In contrast is *figure 2*, the chart of a young woman graduate of a conservative State school for the deaf. She was 19 when she was first seen at the clinic. Her speech is extremely limited. Communicatively and psychologically, she is a deaf person, although her unaided speech-hearing threshold is only a few decibels below the first child's. She has grown up in a world of silence. With a hearing aid she too could perceive simple speech within normal range. She does not know the hearing world, however, and does not want to know it. The mind becomes deaf when the ears are not helped to convey sound.

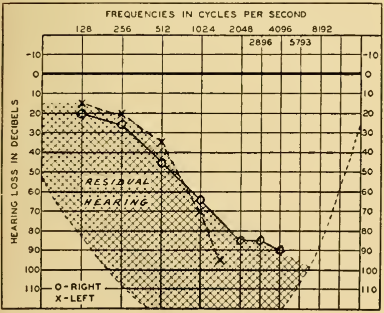
Figure 3, the chart of a 9-year-old boy with nerve-type hearing impairment, illustrates the same point. Audiometric testing puts him at the level where ordinary conversation would not penetrate without a hearing aid. He has had special help at home in language and speech training since he was 3 years old. He has always attended a regular school, where he is doing superior work. His life is entirely normal; he is fully oriented to the world of sound; he is not deaf in any sense of the word, but he would be lost without his hearing aid.

Figure 4 shows the audiogram of a child with severe acoustic distortion. This boy's hearing impairment was caused by chickenpox at the age of 2 months. He is normal in all respects except in hearing ability and language development. Now 5, he has worn a hearing aid since he was 3 years old. Slowly he is making progress in language differentiation. His mother works with him daily. He has also had considerable help from a speech-hearing therapist attached to the school system in which he has been attending a class for normal preschool children. He needs daily school work in language, audition, and speech, but this is not available.

Figure 5 shows the audiogram of a child who is educatively deaf. His impairment is of undeterminable origin. The heavy line represents mathematically his threshold potential for speech-hearing derived from the pure-tone audiogram. Now 5, he has been wearing a hearing aid for 2 years; sound is meaningful to him, but his impairment is so great that sound can never be the foundation for language learning. What he hears is a most useful adjunct to what he sees. He is in a special class for preschool deaf children and demonstrates a rapidly developing language-mind. If this development continues, he should be able to communicate quite understandably by the time he is at a high-school level.

Figure 6 shows an interesting progression of development from awareness of sound to the emergence of language meanings. At 3 years and 2 months the boy whose hearing is charted here had a few unconnected words and some language understanding. He was aware of voice and toy-sounds at the level of 30 to 35 decibels below normal. When the examining otologist found clear evidence of a conductive element in his hearing problem, a tonsillectomy and adenoidectomy were done. The second audiogram, made 5 months later, shows definitely better thresholds for pure tones with quite normal levels in the low-pitch ranges. Awareness had been improved by 10 decibels. The boy was obviously more alert and responsive to sound of all kinds. A third audiogram, made about 18 months after the first, shows that the pure-tone acuity had remained stable. By this time it was possible to test the child's hearing for speech. The resulting 30-decibel level was not considered threshold as few 4-year-olds with distorted hearing can listen to a precise speech-hearing threshold. Auditory meanings were well on the way, however. Now, at the age of 6 years, this child is getting along well in a regular first grade. He wears a very light-gain hearing aid, with a specially adapted earmold.

Figure 4.



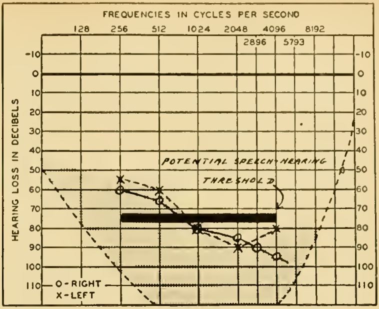


Figure 5.

Some Basic Concepts

A few generalizations can be made from our experience of the past several years in dealing with a large group of preschool children with hearing handicaps. These encompass 10 basic concepts: [1]

1. Hearing rehabilitation is a many-sided cooperative endeavor involving the pediatrician, the otologist, the clinical audiologist, the psychologist, the teacher, and, above all, the parent, working as a team.

2. Communication ability in children with hearing impairment involves acoustic, linguistic, visual, behaviorial, developmental sensory-motor, and social elements. Hearing, speech, and language cannot be isolated from one another or divorced from the overall developmental processes.

3. Treatment and training should be based on a full diagnostic appraisal including an early measurement of the amount of residual hearing, and, when possible, the child's ability to use it.

4. Treatment and training should be started as early as possible in the child's life, preferably be-

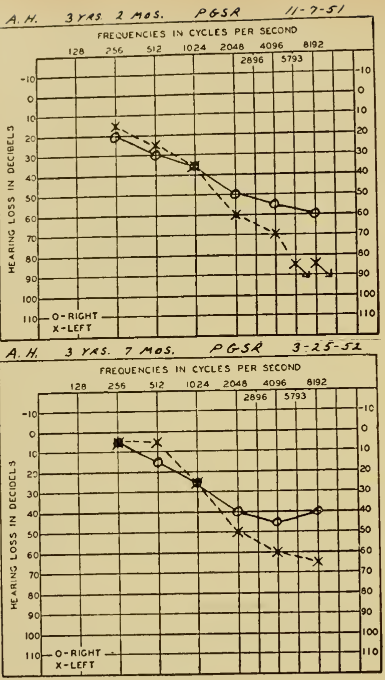


Figure 6.

tween the ages of 18 to 30 months. So far as tools of communication are concerned, the child's career begins in infancy.

5. With appropriate handling, many children having a profound impairment can learn to understand speech and to talk.

6. The majority of children with impaired hearing have a great deal of residual hearing and can make good use of amplified sound, providing this is started at an early age when sound can become an integral part of the developing mind. Even the child with a profound loss can benefit from amplification to some degree.

7. Wearable hearing aids provide the means for putting the child in contact with sound through all his waking hours. Children seem to make the best adjustment to them between 2 and 3 years of age, but the time for providing the aid must be set for each child according to his readiness and needs.

8. Some special handling is always necessary at home and at school for children with handicapping hearing impairment. Whether it should involve special work in a regular nursery school or elementary school or in a special day or residential institution is a task for careful audiologic-educative determination.

9. Most children develop best in a situation that is the closest approach to a normal setting, while meeting their special needs.

10. Parental understanding and parent guidance are the keys to working with children having severe hearing impairment. Progress with the child is usually made in direct proportion to the parents' understanding and acceptance of the problem they face. They need to understand how communication develops, and how they can and must stimulate it in the minute-by-minute experiences of their child. They must be shown how to communicate clearly and simply at short distance, using the same vocabulary over and over in a wide variety of situations, until meaningful associations are grasped and the child begins to relate and store them, and eventually to reproduce them in his own speech. They must learn how to anticipate communicative requirements and to expand the child's vocabulary.

Two Principles

This framework rests on two convictions which have special implications for medicine and education:

1. Although each child is a unique individual, with his own special needs in communicative development, generalized methods can be made to work as the professional team learns to work together.

2. The utilization of modern electronics makes possible an emphasis on hearing, not deafness, in the prospectus of the child's future.

A large group of veteran hearing-aid users under the age of 6 are now giving direct evidence that children with serious hearing impairment can and do learn language and speech if an appropriate program is launched early enough and is followed through in the formative years.

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[1] Pauls, Miriam D.; Hardy, William G.: Hearing impairment in preschool-age children. The Laryngoscope. 63: 534–544, June 1953.

UNPROTECTED ADOPTIONS

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ADOPTIONS ARE POPULAR. Witness the interest the word arouses, in the press, radio, TV, and in any conversation. This widespread interest reflects a drastic change in attitude during the past 2 or 3 decades. For the most part this change is all for the good. To be an adopted child now is to be accepted and approved, and perhaps this is even more true of adoptive parents. On the other hand, a few years ago, an adopted child was more likely to be suspect, pitied, or expected to be eternally grateful for his good fortune.

Popularity has brought with it problems of supply and demand. Since the great demand is for young white babies, the Children's Bureau's explorations were concerned primarily with these babies. The number of such infants available for adoption has increased in recent years, but the rate of increase has not kept up with the demand.

One of the outgrowths of this imbalance between the number of couples who want to adopt and the number of babies available is a practice commonly referred to as the "black market"—the selling of babies for adoption. There is room for wide difference of opinion and judgment on many aspects of adoptions. But the idea of selling babies is intolerable. Nevertheless, the practice continues.

Socially abhorrent as the black market is, there are other adoption situations in which money is not the prime factor, but which expose children to preventable hazards of indiscriminate handling.

When we started our explorations we had no evidence that the black market involved large numbers of babies. What was known about it was serious. But so were conditions surrounding other children being placed by individuals. What we needed most was more information.

I started out by visiting two areas where a black market was known to have existed—New York and Florida. I also visited Tennessee where the head of a social agency had placed children for profit; Chicago and Detroit where the public was aroused about the way in which some adoptions were being handled; and Wisconsin, where medical, legal, and social protections of adoptions were reported to be good.

I talked with directors of public welfare and their staffs, heads of voluntary adoption agencies, directors of maternity homes, public health personnel, judges, law-enforcement officials, doctors, and lawyers in private practice.

I also had access to a great deal of information gathered by a former assistant district attorney in New York City who took part in the prosecution of several black-market rings.

The Child Welfare League of America is conducting extensive research into the practices of adoption agencies. The results of its efforts will go a long way in making known the conditions that surround children and parents served by social agencies. Our concern has been primarily with those mothers and

Evidence of a reprehensible traffic in babies in various parts of the United States prompted the Children's Bureau to undertake an inquiry into unprotected adoptions a year ago. This article, which gives the highlights of the findings, launched the discussion of a conference on "Protecting Children in Adoption," sponsored by the Bureau, in Washington, June 27–28, and attended by representatives of 32 national agencies in the fields of law, medicine, and social work. A report on the conference will soon be available.

children who do not get to a social agency.

Four themes will run throughout this report:

1. Every adoption involves a threefold interest—the child, his natural and his adoptive parents. Measures that protect one protect the other two. And if the interests of one are neglected, the interests of the others are in jeopardy.

2. Knowledge of community resources in the hands of those people in a position to give advice assumes major importance.

3. Prompt handling of the immediate needs of the unmarried mother may determine whether she arrives at an acceptable solution to her dilemma. These needs are for medical care and for help with her own reactions of guilt and the remorse she is very likely to feel.

4. Every mother who relinquishes her child for adoption, every child adopted, every couple who adopts a child, needs medical, legal, and social services. These services cannot be given in isolation. Each becomes most effective when given in coordination and harmony with the other. And conversely, any one provided without the other two leaves the people involved exposed to hazards.

Supply and Demand

All of us know that the demand for babies exceeds the supply. No one has yet figured out how to measure the demand. A frequent estimate by social agencies is 10 requests to 1 placement. Probably this estimate includes duplications.

Unquestionably, there are people who want to adopt children who cannot get one through a social agency. There aren't enough babies who meet their requirements. There are other reasons too. One of them is age. More and more agencies are choosing to place infants with couples under 40. And most agencies place children with couples of the same religious and similar racial and cultural background. Some States require such practices.

Moreover, agencies place only a limited number of babies directly from hospitals. Many agencies are now setting the goal of 3 months for placement of all babies, but some couples choose an independent arrangement for a newborn infant in preference to waiting for an agency baby.

One group that has special difficulty getting children for adoption through an agency is composed of couples associated with the armed forces. These people often are not in one community long enough to make up their minds they want to adopt a child, file their application, have their home studied, receive a child, and complete the adoption before they are transferred. Because agencies are faced with many decisions as to how to use limited staffs in selecting homes for children under their care they usually choose to allocate staff time to couples with stable residences.

Every child needs the security and love of a normal family, agreed the recent Conference on Protecting Children in Adoption. Protection requires that adoptive parents be selected for their ability to provide these emotional needs.

Probably a direct result of this practice is the increasing number of members of the armed forces who are adopting foreign children—as are many other American families. Intercountry adoptions again bring supply and demand into the picture. There are children in Europe and Asia who need new families but meeting the demand for children through this source of supply is not as simple as one man thought it could be. He wanted to charter a plane, fly about 60 babies to this country from Korea and pass them out to any couple who subscribed to his delivery service.

Adoption of foreign children can be the answer for some people. Our concern is how these people, children and parents alike, can be assured the same protections we want for adoptions within our own country.

The Unmarried Mother

Any discussion of adoption immediately leads back to the unmarried mother. Seventy-two percent of the children adopted by nonrelatives in this country are born to unmarried mothers; 150,000 mothers each year give birth to a child out of wedlock; 54,000 are white; 96,000 are nonwhite.

What happens when an unmarried girl suspects she is pregnant? She may refuse to face the possibility and postpone confirmation by medical examination as long as possible. A considerable number of girls actually wait until time for delivery before they seek medical care.

The girl's first step toward advice or help is a vital one. Her actions are controlled to a large extent by the degree of her desire to keep her condition secret. Certainly her knowledge of community resources, or lack of it, will influence her selection of the person or agency to which she will turn first.

One of the first considerations for the girl seeking secrecy is to go where she is unknown. Many girls who leave home want to relinquish their children for adoption. They are looking for the answer to three questions: How to maintain themselves during pregnancy; how to obtain medical care; and what to do about the baby.

From the information available to us, unmarried pregnant girls are getting less medical care, and are getting it later in pregnancy, than married women.

A study made in 1954 in New York City of 154,165 mothers, 8,344 presumably unmarried, showed that by the end of the sixth month of pregnancy, 87 percent of the married mothers had made a prenatal medical visit, as compared with 47 percent of the unmarried.

Four percent of the married women had had no prenatal care, whereas 23 percent of the unmarried women had had none.[1]

Data on premature births and infant mortality suggest further correlation between marital status and medical care. A notably higher percentage of births out of wedlock occur outside of hospitals,[2] and higher rates of neonatal mortality—deaths under 28 days are associated with nonhospital deliveries.[3]

Another important factor is the age of the mother at the time of childbirth. Mortality rates are considerably higher for mothers under 20 than for those between 20 and 24. Some 62,000 mothers under 20 years of age give birth to a child out of wedlock each year.

More research is needed to establish fully the relationship between marital status of the mother, and the extent and timing of the medical care she receives. That the unmarried mother is presently receiving less than she needs, and that there is a direct relationship between this fact and her unmarried status, seem clear.

The unmarried girl must face her own inner feelings as well as the outward reactions of society. If she must also face real difficulty in getting medical care and shelter, she is indeed under serious pressure. For those girls who do get to a social agency early and are offered the kind of help they can use, the pressure is considerably diminished.

Our immediate concern is with those girls who turn to individuals for help. Who are these individuals? They can be any friendly person who will listen to the girl's story. Many of them are people who, because of their profession or because of their position in the community attract the confidence of the unmarried girl—a clergyman, a doctor, a lawyer, a public-health nurse, a schoolteacher, or an employer. We have been told that often this first person is a druggist, possibly because the pregnant girl first thinks of abortion. What the pharmacists know about these girls is still one of our unexplored areas.

How do these people respond to an unmarried pregnant girl's request for help? How can they know how to advise her, and to guide her to resources that will help her handle all the problems involved in being an unmarried mother? Frequently, they do not themselves know of community resources. And all too often, community resources do not exist that will meet the particular needs of the particular unmarried mother.

Community Resources

Data are not available to show the nationwide picture of community resources. However, voluntary and public agencies invariably report inadequate funds and insufficient staff to offer medical care and social services needed by unmarried mothers and their children.

Residence requirements assume great importance in the whole adoption picture in view of the fact that a large number of unmarried pregnant girls leave their home States. Many States and local communities put restrictions on the use of their free services by nonresidents. These may take the form of requiring some clearance with the girl's home State, or some contact with her parents to see if they can assume financial responsibility. The girl's desire for secrecy may prevent her from accepting service under these conditions.

Some Community Chests have urged their member agencies to restrict their services to residents. Some agencies will accept the baby for adoptive placement, but cannot offer the mother any kind of maintenance other than in a maternity home or a wage home. Few agencies have money to pay for private medical care, even though the private physician may have referred the girl to them.

Behind these restrictions on the use of free services by nonresidents lie several explanations. Medical or any other kind of help, some people believe, should not be made easy for these girls, lest it encourage illegitimacy. Some communities fear that if they open their services to all comers they may attract too many and become overburdened with the expense.

One of the most frequent reasons for restrictions is the fear that the child will not be adoptable, and will become a longtime charge on the community or the State. So an effort is made to establish financial responsibility in the State of the girl's residence.

Individual Placements

But agency practices *are* changing, as their knowledge and experience grow. Unfortunately, unmarried mothers and the community do not always know of these changes, and some agencies do not change very fast. If an unmarried mother thinks she will have to give information to an agency about her place of residence and her family, or that she will have to continue some responsibility for the child until he is placed for adoption, an individual's offer of maintenance and medical care with no questions asked may seem preferable. What she often fails to realize is that with such an offer, she must pay a price, a price she is not prepared to evaluate at the time—her child.

We know that usually one of the first concerns of an unmarried pregnant girl is medical care. Naturally she turns to a doctor. The childless couple turns to a doctor for help in getting a baby to adopt. The doctor naturally thinks first of the well-being of his patient. The pregnant girl and the childless couple may be his patients. He may look upon adoption of the child as a way out of an embarrassing situation for the girl, and a way to happiness for the couple. What the child may need can be lost sight of in concentrating on the needs of the patients. We know that some adoptions arranged by family physicians are successful. However, I have been told of doctors who are obtaining babies for couples who are not their patients and whom they do not know.

I have had a number of doctors tell me of a couple who has come to them because they do not have children. The wife is distraught. Her desire for a child has become an "obsession." Doctors have told me they feared the wife would have a mental breakdown if she did not get a child. And they have helped her to get one.

The unmarried mother may be directed to a doctor known to welcome such patients because he has found that adoptive couples are more than willing to pay whatever professional fee is asked in order to get a baby. Similarly, unmarried mothers may be directed to certain lawyers who are eager to act as intermediaries in an adoption.

State Legislation

State laws affecting children going into adoption are scattered throughout the statute books. Besides laws that apply to the procedure of an adoption petition through the court, at least four other kinds relate directly to adoption and to the three parties to it:

1. Laws relating to voluntary and involuntary termination of parental rights.

2. Laws relating to relinquishment and the right to consent to adoption.

3. Laws relating to the licensing of child placing agencies, foster homes, and maternity-care facilities.

4. And laws specifying who can and who cannot place a child for adoption.

Every State has developed its own particular legislative framework surrounding adoptions. The points at which the forces of protection of children are brought to bear vary with States and communities. In some communities the case of every unmarried pregnant girl who is a minor is subject to review by the court or some authoritative agency to determine whether she is in need of special protections. Some States seek to protect the child born out of wedlock by requiring that the birth be reported to the department of welfare.

Other States bring their protective forces to bear at the time the child is placed in the adoptive home by requiring that the placement be made by a person or agency licensed to do so. Others require investigation after the adoption petition has been filed and after the child may have been in the home some months.

Obviously, with all these variations in State laws regulating adoptions, the opportunity for evading any one or all of them is open to any person who wants to do so—especially where there is no agency that has been designated to enforce the protections.

Take for example, the filing of adoption petitions. Some States require that these be filed in the petitioners' State of residence. Usually an accompanying law requires a social study of the petitioners' home. Such laws give importance to establishing the suitability of the couple to adopt a particular child.

Other States have no such requirements. Any couple may file a petition to adopt a child without regard to their residence. This means that a couple found unsuitable to adopt a child in their home State might obtain one in another, file their petition, and return home with the baby.

Areas for Consideration

While many honest differences of opinion exist as to the criteria for selecting adoptive parents, most people would agree that some couples who want to adopt a child are not suitable prospective parents. Serious consideration must be given to how children can be protected from adoption by couples who can neither offer the child a reasonably happy future nor achieve happiness for themselves by this route.

One desirable protection for all parties in an adoption is that, once it has been completed, the child not be disturbed by having two sets of parents. The safest way to prevent this is to provide for termination of parental rights and placement of the child in such a way that the natural parents do not know where the child is placed. Some statutes prohibit placement by other than an authorized agency, but exempt the mother from this prohibition. This, while recognizing certain parental rights, has inherent dangers for all concerned and calls for a careful examination of the philosophy of the law to see how it can insure the rights and responsibilities of all—the child, his natural and his adoptive parents.

What often happens is that, despite a prohibition against individual placements, an unauthorized intermediary takes over, ostensibly acting for the mother. Often a person who knows of an unmarried mother seeking to relinquish her child and a couple wanting to adopt one acts as the arranger between the two parties. The intermediary often defends this practice on the grounds that he is protecting the child and his adoptive parents. This is one of many situations in which the independently arranged adoption is only made by evasion, manipulation, or actual violation of the law.

Two kinds of situations are being reported with sufficient frequency to give reason for grave concern. One is the registration of the unmarried mother in the hospital under the name of the adoptive mother. Presumably the child is reported as being born to the "adoptive" mother and therefore is never adopted. This means falsification of the birth record. The child is left without a clearly defined legal status. How can the parents live but in fear that the falsification will become known? No matter how much a child is treated as the parents' own, the fact that he is not is known to the people in whom the child is most likely to sense fear and uneasiness—his parents. Such children are very likely to learn of their status sooner or later. Experience is overwhelmingly in favor of the adopted child learning from his adoptive parents his status in the family.

Another kind of legal situation with inherent problems is that of the married woman whose husband is not the father of her child. Usually such a child is recognized as legitimate unless proved otherwise, and therefore the husband's consent to the adoption is required. If the mother does not want her husband to know about the child and wants to release him for adoption, she faces legal as well as emotional problems. Women in such difficulties have turned to the black market and to others who are unconcerned with such legal requirements. Certainly the best legal and social thought is needed to find a way of dealing with such situations.

Many abuses have been reported around a mother's relinquishment of her child. Some of the most vicious cases that have come to light from the black market are those in which a girl has been frightened or coerced into signing a relinquishment before or immediately after delivery.

Contested Adoptions

Frequently newspapers carry stories of contested adoptions. The natural or the adoptive parents are dissatisfied with the arrangement. These cases are tragic in the damage and hurt they cause. They are comparatively few out of the total number of adoptions, but there are many more cases in which great harm is done that do not make the headlines.

A young girl from a small town in Kentucky went to Detroit when she found she was pregnant. She told her family she had a job there. She found a friendly druggist who could not help her with her first question, but offered to get her to a doctor who would give her medical care. The doctor assured her of maintenance, medical care, and sufficient money to start her on her way after the birth of her child. He knew of a couple who would pay all these expenses if they could have the baby.

Detroit rigidly enforces a law that in any independent adoptive placement the home must be studied before the child is placed in it. This means that the baby must first go into a temporary boarding home until a report is made to the court on the suitability of the adoptive home.

The girl delivered her child, was visited by the attorney of the adoptive couple, left the hospital, signed a relinquishment, and returned to her home saying only that she did not like working in Detroit.

The baby was taken to a temporary home to await the report to the court. In the meantime, the adoptive couple's own doctor examined the baby and found him to be abnormal. The couple refused to take the child. The attorney got in touch with the girl at her home and told her she would have to come for her baby. Even though she had signed a relinquishment, she was still legally responsible.

Sometimes the situation is reversed. The adoptive couple takes the baby and is extremely happy with him. It is the girl who changes her mind. If her rights have not been terminated, and if she knows where her child is, she may contest the adoption, with tragic results for everyone concerned.

Can such contested adoptions be prevented? For the most part, yes. If the mother is helped with her emotional problems at the time she must make the decision to keep or to give up her child, she is very likely to make a decision she can live with.

One of the most frequently reported characteristics of individuals who arrange adoptive placements is their lack of concern with the future of the natural mother. Besides humanitarian interest in helping girls in trouble, another important reason exists for being concerned about their future. Most of them are in the early years of their childbearing period. Most of them will have more children, hopefully in wedlock. The community has a real stake in helping these girls become stable wives and mothers.

Federal legislation has been suggested aimed at preventing and controlling the black market. These proposals would make it a Federal offense to transport a mother or a baby across State lines for the purpose of selling the baby for adoption.

The little specific information we have on black-market operations indicates that the interstate movement of the mother is voluntary and not controlled by the black marketeer. The transporting of the baby is by the adoptive couple. Therefore, the proposed legislation would not be effective in controlling the activities of the intermediary. True, one of the black-market rings that was exposed and prosecuted involved the transporting of babies from Florida to New York, but we have no recent information that any such rings are in operation.

One kind of suggested Federal legislation would make it an offense to transport a baby interstate in violation of the laws of the States involved. Where State laws are weak, such a Federal law would be ineffective. It would, however, keep responsibility within the States, and might be used to urge States to strengthen their laws.

A Community Responsibility

Inherent in the effectiveness of the law is the community's attitude toward it. If the community does not know about the law, or knows about it but does not accept it, or accepts it but will not give money for the services required, the protections provided by the law can have little effect.

Twenty thousand children a year are placed with nonrelatives by individuals for adoption. We do not know how many of these children lack adequate protections. We need to find out. But even more we need to find out what protections are essential and how they can be obtained.

Until the professions which are directly concerned can arrive at a consensus of what medical, legal, and social protections are needed, there seems little hope that the black-market and other unprotected adoptive placements can be prevented.

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[1] City of New York Department of Health, Bureau of Records and Statistics. Unpublished statistics based on material from confidential birth certificates. 1954.

[2] National Office of Vital Statistics, Public Health Service, Federal Security Agency: Report on illegitimate births 1938–47, vol. 33, no. 5, Feb. 15, 1950.

[3] ———, Department of Health, Education, and Welfare: Weight at birth and its effect on survival of the newborn in the United States, early 1950. Vital Statistics Special Reports, vol. 39, No. 1, July 23, 1954.

Are programs of parent education reenforcing or undermining parents' confidence? An expert discusses . . .

THE CRITICS AND PARENT EDUCATION

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IS THERE an anti-expert trend in parent education? Some people say there is. I for one do not know. Certainly there is a great deal of criticism. But is it proportionately greater than heretofore? I say "proportionately" because there is so much more parent education than there used to be, that perhaps it is only natural that there should also be more criticism. Granting that there is a lot of criticism, what are the reasons?

In trying to analyze reasons, perhaps a little speculation about the motives of the critics is relevant. Some of them I am convinced are critical out of genuine humility. They are impressed by the intuitive wisdom of many parents; they are aware of their own fallibility; more and more they challenge their own assumptions; and presently they get caught up in an excess of doubt which expresses itself in pronouncements to the effect that "Nobody knows anything about anything." A certain amount of this attitude is healthy. Too much almost surely leads to confusion and defeatism.

Some critics make sweeping indictments but fail to think through the implications of their recommendations. "Let parents alone," they say. Does that mean, then, that we should make no effort to pass on today's new knowledge? "Parents are confused" is one of their war cries. Incontrovertible. But does that mean parents should not be exposed to new ideas? "The wisdom is within the group." But how about the errors? They are within the group too.

Some criticism of this kind is sincerely intended to be constructive, and may indeed prove to be so at times, but some of it is clearly hostile and destructive.

Some people do not have the skill to build up, and so they tear down. In this category I would place the headline seekers. If they cannot get attention from their own work, they will get it by pointing out flaws in the work of others. When a job is hard to do, as is parent education, it is always easier to point out what is wrong than to set about trying to do better. The pointer-outers can usually count on the enthusiastic support of the press, which is never so happy as when it can report that someone "blasts" or "flays" someone else—preferably another "expert." Some newspapers may even give a little twist here or a mite of distortion there, or lift a point or two out of context, in their search for "news" or an "angle" playing up an apparent row between experts. There is always a sizable segment of the reading public that glories in the deflating of any kind of so-called expert, particularly if that person has the temerity to claim any special knowledge about children. Doesn't every adult secretly regard himself as an expert on this subject?

How To Evaluate?

Apparently, then, there are more than a few reasons why parent educators might as well expect to come in for rather more than their share of being taken to pieces. What they want to know is how to decide how much criticism to take seriously and how much to shrug off. That brings us to some key questions about how they can measure the value of what they are doing.

Conscientious parent educators strive hard to improve their work. They are convinced that what they are trying to do is worth doing. They usually have a feeling of accomplishment. But that does not mean their heads are in the clouds. They are capable of self-criticism. They are willing to examine themselves. If their methods are not effective, they want to know it. If their materials are not valid, they want to know that. *How are they to judge the effectiveness of their work?*

This question puts us squarely in the middle of the evaluation problem. What *do* we know about what parent education accomplishes? How *can* we tell which work is worth the effort and which is not? Although sounding fairly simple, these are among the knottiest questions we are facing today. When it comes to matters psychological and things having to do with the interpretation and modification of human behavior, we are all more sophisticated than we were a few years back. We are less starry-eyed about our own new ideas. We are eager to differentiate between wishful thinking and proof. We are less willing to depend on opinion, even when it represents a consensus of thought.

But I for one am rather discouraged about studies of evaluation. When I see them in the literature, I reach for them eagerly. I keep hoping somebody will have evolved a brilliant new technique I have never heard of. Too often, however, so-called "evaluations" turn out to be simply another array of opinions. Or if they pretend to some degree of objectivity, then often it seems as if the investigators, in an effort to control the multiplicity of variables, have squeezed all the "value" out of "evaluate."

In another article[1] I have grappled with the problem of criteria of effectiveness. Frankly, they are not impressive.

Current Criteria

Two major criteria are in everyday use, whether consciously or not. The first is popularity, or demand. If a piece of material—a book, a film, a lecture, a radio program—is well liked by the public for which it is intended, there is often a blind assumption that it is therefore effective and accomplishes the purpose it sets out to accomplish. A moment's thought shows that this is not necessarily true. Because something is popular is no proof that it is effective. However, if it is *not* popular, then it is definitely not effective—a point too often overlooked by ivory-tower scientists and educators who do not like to be bothered trying to make their material understandable.

The second criterion on which we lean heavily is the opinion of authorities. The unreliability of this criterion is never so apparent as when authorities differ among themselves. Even when they agree, we rarely have the kind of proof that will stand rigid tests of scientific validity.

In spite of this, I happen to think than when these two criteria are put together—popularity, or demand, and the opinions of authorities—we have at least a reasonably good guide as to value. Pernicious stuff may be popular, but it will not be approved by really thoughtful and experienced authorities. Dull, incomprehensible stuff may be approved by authorities, but it will not be well liked, and therefore will not be used. When a piece of material or a technique is both approved by those who have given the subject the most study, and well liked by the audience for whom it is intended, the chances are that it has a certain amount of value.

Increased Sensitivity

When I feel frustrated at our inability to *prove* the value of parent education, I take consolation in my conviction that we are moving on a desirable course. When you are on a strange country road you do not have to know where you are at every moment if you are reasonably sure you are going in the right direction. I feel that we are moving ahead because I have confidence in our steadily increasing body of knowledge about people.

We are far more sensitive to many things than we were 20 or 30 years ago. For instance, we are more sensitive to the potential gap between learning and teaching. We are less willing than formerly to assume that any person, whether child or parent, is learning what we are trying to teach. We are not satisfied to sit back and say "This is what I am teaching." We see the necessity for turning the spotlight on the question "What is that person really learning?" (What a shock it is sometimes to find out!)

We are more sensitive than we used to be to the many factors that enter into the learning situation: to motivation and identification and resistance; to readiness and timing; to anxiety and unconscious feelings. True, there are also some things about which we are not nearly sensitive enough, such as the futility of exhortation, and of admonishing parents to change their feelings and their character structure.

We are more sensitive to the fact that there are different *kinds* of learners. We can almost visualize a sort of readiness-resistance scale of learning, with a parent's standing on this scale determining what and how much he is able to absorb in any parent-education situation.

I like to think of parents as roughly divided into "levels of readiness." The first is the level of "simple ignorance." The parent—let us say a mother—does not know certain things about children which she wants to know. She is ready and eager to learn. When she is told things, she understands. She uses what she has learned. Because her mind is open and receptive, she needs only to be exposed to good parent education.

A second level of readiness is represented by the kind of mother whose ignorance consists not merely of naive "not knowing" but of knowing the wrong thing. A mother of this type is apt to be resistant to new ideas, set in her ways, full of faulty notions. She will not learn nearly so fast as the first mother, but neither is it impossible to teach her under the right circumsances. Mere exposure to parent-education materials is unlikely to be enough, but she is reachable if the techniques and content are tailor-made to her requirements.

The third level of readiness, or rather of unreadiness, is represented by the mother whose ways of thinking and doing things are traceable to anxiety and emotional disturbance. This mother may not be reachable at all by ordinary methods of parent education unless it is possible first to deal with her own personality problems.

Professional people who are accustomed to dealing primarily with but one of these types of mothers sometimes generalize erroneously from their experience. For instance, clinicians who spend most of their time seeing only mothers with personality disturbances are likely to say "Nobody learns from reading." True, most mothers in the third category are unlikely to learn from reading. But this is not necessarily true of the mothers in the first category, many of whom get a great deal from reading.

A similar mistake is sometimes made in the opposite direction. Professional workers who are accustomed to dealing with young mothers who are reasonably well adjusted and eager to learn, may surmise that all you have to do in all cases is to point out mistakes or *tell* them something and they can absorb it. With the third category of mothers, "telling" is notoriously ineffective; with the first it may be all that is necessary. When these differences are recognized, materials and methods can be adjusted accordingly. These points about levels are developed more fully in "Health Supervision of Young Children." [2]

Continuous Assessment

Let us return to the question of how parent educators are to judge the effectiveness of their work. I have been trying to answer this by squarely facing the fact that up to now we have few if any real measures of effectiveness. We are rarely able to say "such and such is a good method and here is the proof." Instead we are nearly always obliged to rely on the combination of demand and opinion. They may give us a *guide* as to *probable* value, but they do not give us *proof* of value.

Although it seems painfully unscientific to say so, I have gone out on a limb and declared myself as thinking that under the right circumstances the combination of these two criteria—demand and opinion—gives a reasonably good guide to effectiveness. Moreover I have admitted to a personal conviction—unproved to be sure, but deeply held—that we are moving in the right direction in increasing our body of knowledge about children and families and behavior. Since much of this knowledge takes the form of increased sensitivity to the many factors affecting learning, I believe that as sensitivity increases, effectiveness in parent education will also increase. The criticisms of the "anti-experts" should be weighed thoughtfully, to see what we can learn from them, but should not be allowed to undermine the confidence of parent educators in their own work.[3] The important job is to assess what we know and what we do not know in parent education, and keep moving in the directions that we think are right.

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[1] Ridenour, Nina: Criteria of effectiveness in mental health education. American Journal of Orthopsychiatry, 23: 271–279, April 1953.

[2] American Public Health Association: Health supervision of young children; a guide for practicing physicians and child health conference personnel. New York. 1955. pp. 180. See pp. 44–47.

[3] Ridenour, Nina: Code for Snipers. *In* children here and now: notes from 69 Bank Street. 1954. p. 4.

JUVENILE DELINQUENCY AND *ANOMIE*

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ONE of the most provocative discoveries to be made about juvenile delinquency in recent years has emerged from an analysis of court statistics and census-tract data in Baltimore. The report of this study, "Toward an Understanding of Juvenile Delinquency," by Bernard Lander[1] is important not only for what it tells about juvenile delinquency and the author's explanations of his findings but also for what it shows about the way he arrived at his discovery. This method, in fact, may be its most important contribution, for it is a warning that there is no short and easy way to determine the significance of the facts that are represented by some of the most familiar statistics of social work.

Lander's study is based on the juvenile-court statistics of Baltimore for 1939–1942. In those years 7,193 different children appeared before the court in 8,464 official hearings. This represented an annual rate of court appearance of about 10 per 1,000 population 6 to 17 years old.

Delinquency (defined as court appearance) was more frequent among boys than girls and among Negroes than among white children. During this 4-year period something like 40 percent of the Negro boys 14 or 15 years old appeared before the court and 26 percent of those who were 10 to 13 years old. For white boys the corresponding figures were 12 and 7 percent respectively.

Delinquency, as expected, was much more frequent in some parts of the city than in others. Several census-tract areas sent no children to court during the 4 years under consideration, while in one tract the average delinquency rate was 21 per 100 children.

The areas of the city where the delinquency rate was high were characterized by substandard housing, overcrowding, lack of home ownership, a low level of education. In short, they were poverty-stricken areas.

So far, it is the old story. But is it the whole story? Is there really such a close connection as is usually supposed between juvenile delinquency and these often-observed facts of economics and race? The answer in Lander's study is no.

The purpose of this article is to show how Lander arrived at that conclusion, what factors he did find significantly related to delinquency, and what this implies for delinquency research.

The Method

The measurement of the amount of association among variables is the statistician's job, and for that measurement the modern statistician has several tools. The tool he has most frequently used in analyzing delinquency statistics is simple "zero-order" correlation. By this means the association between an individual variable (such as race or degree of overcrowding) and delinquency is worked out. This result leaves unanswered the question of how closely the different variables are themselves associated—for example, how closely race and income and kind of housing and amount of education are connected, and whether their connection obscures the influence of any one of them on delinquency. The statistician, however, has other, more refined methods of analysis that he can, and should, use in studying such complicated interrelationships. What happened when

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these methods were used in the analysis of the Baltimore figures is the gist of our story.

The first point to be emphasized in telling that story is that this study dealt with census tracts—the 155 of them that compose the city of Baltimore—rather than with individuals. In other words, the question under consideration was how closely a tract's delinquency rate was paralleled by its rate of inadequate houses, Negro population, or other trait, and which factors on the list of variables were most closely associated.

The second point to be made concerns the list of traits studied. Limited to factors about which information existed in statistical form, they were: (1) proportion of children delinquent; (2) proportion of population nonwhite (racial heterogeneity); (3) proportion of foreign-born; (4) median years of school attendance; (5) median rental; (6) proportion of substandard houses; (7) proportion of overcrowding; (8) proportion of homes occupied by owner.

Now, what was discovered about the relations between these traits and delinquency?

First, when the simple correlations between the delinquency rate and other traits were worked out one by one the usual findings emerged. There was a high association between each of these traits (except percentage of foreign-born) and delinquency:

1. Percentage of homes owner-occupied	−.80*
2. Percentage of overcrowding	+.73
3. Percentage of nonwhites	+.70
4. Percentage of substandard housing	+.69
5. Median rentals	−.53
6. Median school years of education	−.51
7. Percentage of foreign-born	−.16

This is where most statistical studies stop—except that the writers may go on to compound the error of inadequate statistical analysis by drawing erroneous conclusions—for instance, that poor housing causes delinquency. Correlation, it may be said parenthetically, does not demonstrate cause under any conditions, whether the statistical method used is crude or refined. It only shows that two things go together—and this may be because they are both influenced by a third thing, or by nothing at all.

Lander went further in his statistical analysis by correlation method for at least two reasons. First, in social phenomena there is seldom a simple relation between two traits, such as delinquency and race. Usually many other traits are involved, which themselves affect each of these two variables. Second, the product-moment method of correlation used to obtain the findings cited above assumes that a linear relationship between the two variables exists—for instance, that the poorer the housing or the higher the proportion of Negroes in an area, the higher the delinquency rate. Close inspection of the data broken down into subgroups showed that this assumption was not always justified.

For example, it was found that up to a certain point the delinquency rate increased as the percentage of Negroes increased. But when the percentage of Negroes reached 50 percent the delinquency rate began to go down. In areas predominantly Negro, the delinquency rate was no higher than in corresponding white areas.

Data Analysis

This being so, Lander moved on to analyze his data by a process called partial correlation. Partial correlation is a method by which the association between delinquency and another trait, such as substandard housing, can be measured, with the influence of the other factors—race, education, and the others—being excluded.

In addition, Lander adjusted his partial-correlation coefficients to take account of the fact that the relationships were not linear.

The findings that emerged from these two operations greatly changed the conclusions about the association between delinquency and the variables under consideration. This analysis indicated that when other traits were held constant, instead of a high relationship, no relationship existed between delinquency and substandard housing and overcrowding. Only two traits stood out as being significantly related to delinquency in Baltimore: the racial heterogeneity of an area and the percentage of homes that were rented instead of owned.

As a check on these findings and in an attempt to learn more about the implied relationships, Lander then decided to use another tool of statistical study, factor analysis. This is a method by which one can determine whether there is an underlying order among a series of variables; that is, whether some groups of them do and some do not go together. In particular, his interest was in seeing in which group of associated traits, if any, delinquency belonged.

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*A perfect correlation is 1.00. "Plus" indicates that the traits—for instance, delinquency and overcrowding—are positively associated; "minus" that they are negatively associated—for example, the more delinquency, the fewer homes owned by the occupants.

Through this kind of analysis, Lander found that the traits he was studying exhibited two groupings, with one trait—percentage of foreign-born—not belonging to either group. One group consisted of four traits: median rental, percentage of overcrowding, percentage of substandard housing, and median years of schooling. The other consisted of three traits: degree of racial heterogeneity, percentage of homes owner-occupied, and the delinquency rate. The two sets of traits were apparently related to each other but only in the second set was the delinquency rate found.

The Interpretation

What does this mean? The variables being studied were obviously not factors determinant of delinquency in and of themselves. They were only descriptive figures, or indices of something or other. All the analysis showed was that in Baltimore's census tracts, on one hand, low rent, overcrowding, substandard housing, and little schooling went together; on the other, a high proportion of racial heterogeneity, a low proportion of homes occupied by their owners, and a high delinquency rate went hand in hand. And, to a certain extent, the tracts that had one of these sets of traits also had the other set of characteristics.

What underlies each of these sets of traits; what is it that they are pointing to? The answer cannot be determined by statistics. It calls for logic, the application of previous knowledge and theory to the situation at hand.

Lander conjectures that the first set of traits evidences an economic factor at work, and that the second set—the proportion of Negroes in a tract, the proportion of homes occupied by the owner, and the delinquency rate—indicates what certain sociologists have called *anomie.*

Unfortunately for research, *anomie*—normlessness—is a rather vague term. It was first used in modern times by the French sociologist Durkheim [2] in a brilliant, highly suggestive study of suicide. Parsons [3] and Merton [4] have picked it up and elaborated upon it. The term refers to the condition of social disorganization or social instability in which the power of social norms to control the conduct of individuals is slight—perhaps because the norms (the rules of the game in social life) are not clearly expressed or firmly implemented or sharply because conflicting norms obtain in the area under consideration. This condition of normlessness leaves people at loose ends, not knowing how they ought to behave and often not caring. That it would lead to delinquency on the part of many youngsters—as well as perhaps apathy, confusion, or disgust on the part of others—seems theoretically at least, obvious.

Lander's thesis is that, in Baltimore, neighborhoods characterized by a high proportion of rented homes and a high degree of racial heterogeneity are the ones most likely to be disorganized, unstable, lacking in a clear sense of social values. This would not necessarily be true of other cities. For them, some other indications of normlessness might have to be found if one wanted to see whether delinquency and *anomie* go together.

For Baltimore, however, he concludes, that the chief explanation of the differences among census tracts in rate of delinquency is to be found not in economics but in social organization. More children become delinquent in certain parts of the city than in others not because money is scarce but because social life is disorganized. Children cannot regulate themselves in accordance with conventional norms when those norms are vague or dimly formulated in the social group (family and community) in which they live or where there is a conflict of norms with no clear consensus as to which are right. This normless condition is more likely to obtain in the slums than in the suburbs but it is not a necessary concomitant of poverty; nor, we might speculate, is it necessarily absent under conditions of wealth.

Directions for Research

This last observation leads to my next point: Where do we go in further research? Obviously, the first thing to do is to check upon the validity of Lander's findings. Do the statistics of other cities tell the same story? In cities unlike Baltimore in racial heterogeneity and home ownership are there other indices of *anomie?* In any city, what additional data indicative of social instability might be adduced that would serve as a check on these findings?

Second, what about *anomie* itself? Can it be better defined? If it does exist, by what is it indicated? What are the signs and symptoms of this sickness of the social soul?

Third, if *anomie* can be operationally identified, will it be found to exist in certain more prosperous segments of society also? Does it correlate with the incidence of behavior disorders, if not of official delinquency, among children in such areas?

Fourth, if this discovery of an association between normlessness in an area and delinquent conduct on the part of its inhabitants is confirmed by other studies, what is the process by which the one leads to the other in the individual case? Sociology and psychiatry already give hints as to the answer but much more detailed analyses of individual, family, and community histories will have to be made before the dynamics of the process become clear.

So much then for some ideas about future research. As to implications for prevention of delinquency, they can be drawn only on the assumption that this one study proves the point. Without claiming that this is so, but rather affirming that research and practice should go hand in hand, I would suggest that this study bolsters the claims of those who seek delinquency prevention in community reorganization, in the reaffirmation of moral values, in the practice of genuine democracy throughout our society, in any and all measures that give parents and children a clear sense of social direction and purpose. If measures looking to these ends can be devised and carried out, their effects on youthful conduct will provide the best test of the correctness of Lander's hypothesis.

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[1] Lander, Bernard: Toward an understanding of juvenile delinquency. New York: Columbia University Press. 1954. 143 pp. $3.

[2] Durkheim, E.: Division of labor in society, Translated by George Simpson. New York: Macmillan Co. 1933. pp. 297–301.

[3] Parsons, Talcott: The structure of social action. New York: McGraw-Hill Co. 1937. p. 377.

[4] Merton, Robert K.: Social structure and anomie. *In* Social theory and social structure. The Free Press, Glencoe, Ill. 1951.

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CEREBRAL PALSY; methods of evaluation and treatment. George G. Deaver, M. D. Rehabilitation monograph IX. Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York. 1955. 57 pp. $1.

Latest of a series of monographs dealing with various aspects of rehabilitation and services to the handicapped. Presents information on the etiology, pathology, diagnosis, and types of cerebral palsy; also the methods which in the author's experience have proved most successful in meeting the total needs of the cerebral-palsied child and his parents.

A GUIDE FOR LEADERS IN PARENT AND FAMILY LIFE EDUCATION. Pearl T. Cummings, Dan C. Overlade, and Dale B. Harris. Institute of Child Welfare, University of Minnesota, Minneapolis. 1955. 77 pp. $1.

Outlines a course in local leadership for parent-education groups and gives detailed suggestions for using devices such as films and tape recordings. Includes in the content of such a course such subjects as parent-teacher relationships, self-reliance and responsibility, emotional development, adolescence, and sex education. Suggests practical steps for borrowing the 18 tape recordings prepared by the Institute.

ON CULTURAL FACTORS IN CASEWORK. Sol Wiener Ginsburg, M. D. National Travelers Aid Association, 425 Fourth Avenue, New York 16, N. Y. 1954. 19 pp. 35 cents.

Discusses the effects of culture on the social caseworker, the client, and the casework process. Some factors, apparently cultural, says the author, turn out to be highly personal elements in which the culture merely sets the backdrop for the acting out of the client's personal problems.

WORKING WITH THE CHILD AND HIS PARENTS. Child Welfare League of America, Inc., 345 East 46th Street, New York 17, N. Y. 1954. 23 pp. 60 cents.

Presents two papers, reprinted from the *Social Service Review*, September 1954: "The Casework Process in Working With the Child and the Family in the Child's Own Home," by Mary E. Rall, and "Treatment After Placement," by Esther Glickman.

WHEN PARENTS GET TOGETHER; how to organize a parent-education program. Gertrude Goller and a staff committee of the Child Study Association of America. The Association, 132 East 74th Street, New York 21, N. Y. 1955. 47 pp. 50 cents.

Advises parent groups on such points as how to get the education program started, what to do about publicity, how to use local and national resources, how to find and develop leaders. An appendix lists resources for program materials.

SAFEGUARDING THE EMOTIONAL HEALTH OF OUR CHILDREN; an inquiry into the concept of the rejecting mother. Anna Freud. Child Welfare League of America, Inc., 345 East 46th Street, New York 17, N. Y. 1955. 16 pp. 50 cents.

"Rejection" of a child by his mother, says Miss Freud, is a vague concept and through overuse has become almost meaningless. She defines various types of rejection growing out of a mother's unwillingness, her abnormality, her separation from her child.

INDIVIDUAL DEVELOPMENT. Lawrence K. Frank. Doubleday & Co., Garden City, N. Y. 1955. 52 pp. 85 cents.

Explores the development of the child and reviews some studies that show what is involved in individual development. Differentiates development according to the internal environment, motor patterns and locomotion, communication through language, and cognitive and symbolic processes.

BOOK NOTES

GROUP THERAPY FOR MOTHERS OF DISTURBED CHILDREN. Helen E. Durkin, Ph. D. Foreword by S. R. Slavson. Pub. 236, American Lecture Series, edited by Molly Harrower. Charles C Thomas, Springfield, Ill. 1954. 125 pp. $3.50.

This book tells how regular group meetings with a psychotherapist have helped mothers to gain insight into their attitudes toward their children. Over a period of about 15 years the psychoanalytically oriented method described has been applied to about 100 groups of mothers. In the future the author hopes to expand the work to include fathers.

GUIDANCE IN A RURAL-INDUSTRIAL COMMUNITY; Harlan County—A Kentucky coal-mining district plans with and for its boys and girls. Amber Arthun Warburton. Preface by Ruth Strang. Alliance for Guidance of Rural Youth and Department of Rural Education, National Education Association of the United States, 1201–16th Street NW., Washington 6, D. C. 249 pp. Paper, $3; cloth, $4.

Two decades of a guidance program in a mining community are described in the first part of this report. The second part records appraisals of the program by teachers, principals, the boys and girls themselves, parents, and others in the community.

GROUP WORK AND COMMUNITY ORGANIZATION, 1953–54; papers presented at the 80th and 81st annual forums of the National Conference of Social Work. Columbia University Press, New York. 1954. 104 pp. $2.25.

The nine papers included in this collection are addressed to supervisors, practitioners, and volunteers in the fields indicated by the title. Subjects include agency-intake practice, activities for disturbed children, community studies of living conditions, evaluating individual members of a group, similarities and differences between social work and education, measurability of need for social services, participation of official agencies in community programs, and international social action.

EXPANDING HORIZONS IN MEDICAL SOCIAL WORK. Edited by Dora Goldstine. University of Chicago Press, Chicago. 1955. 275 pp. $5.

This second work completes the late Miss Goldstine's compilation of selections from the literature of medical social work, which began with her "Readings in the Theory and Practice of Medical Social Work" (1954). The present volume is divided into 2 parts, 1 noting the contributions of medical social work to medical care, the other the participation of medical social workers in the professional education of social workers and others.

FLUORIDATION AS A PUBLIC HEALTH MEASURE. Edited by James H. Shaw. American Association for the Advancement of Science, Washington. 1954. 232 pp. $4.50.

Addressed to the public-health worker, the civic official, the waterworks engineer, and the interested layman, this volume, consisting of about a dozen papers by scientists in different fields, offers what the preface calls "a reasonably complete evaluation of the present knowledge of the relation of fluoride ingestion to human health."

THE GROWING FAMILY; a guide for parents. Edited by Maxwell S. Stewart. Foreword by Sidonie Matsner Gruenberg. Harper & Bros., New York. 1955. 256 pp. $3.50.

This book is addressed primarily to parents, teachers, and others who deal directly with children. It is composed of individual pamphlets originally published by the Public Affairs Committee.

HOW TO WORK WITH YOUR BOARD AND COMMITTEES. Louis H. Blumenthal. Association Press, New York. 1954. 64 pp. $1.

Social workers and board members need each other's support, says the author of this book—a support that is more likely to be forthcoming when each is sensitized to the attitudes, the thinking, and the working methods of the other. The book traces the evolution of the board-staff partnership, describes how it operates, and shows that the basic factor is an understanding of board and staff members as individuals and as human beings.

FEEDING YOUR CHILD. Samuel M. Wishik, M. D. Forward by Leona Baumgartner, M. D. Doubleday & Co., Garden City, N. Y. 1955. 223 pp. $3.50.

Mentioning the common things that happen in connection with feeding, and suggesting what *might be done,* about them, the author maintains throughout this book that "the right method is the one that is right for you." For example, his first chapter, "Shall I Nurse My Baby?" addressed to the pregnant woman, makes the point that "the final decision is yours." Nearly three-fourths of the text applies to infants.

CEREBRAL PALSY; its individual and community problems. Edited by William B. Cruickshank, Ph.D., and George M. Raus, M.D. Syracuse University Press, Syracuse, N. Y. 1955. 560 pp. $7.50.

In this collection of papers by several authors, the editors have brought together medical, psychological, therapeutic, social-work, and rehabilitation points of view on the cerebral-palsy problem. Part A, Diagnosis and Assessment, takes up the magnitude of the problem, its medical aspects, evaluation of cerebral-palsied children's intelligence, their personality characteristics, and their hearing and speech problems. Part B, Planning for Life Adjustment, discusses physical and occupational therapy, educational planning, mental retardation, parent education and counseling, vocational guidance and placement, social casework, rehabilitation, and total community planning for the cerebral palsied.

CHILD DEVELOPMENT. Millie Almy. Henry Holt & Co., New York. 1955. 490 pp. $6.

Using 6 life stories derived from longitudinal studies conducted by the Harvard School of Public Health as a framework, the author first depicts the young people at the age of 18. She then goes back to the time of their birth, describing the families into which these boys and girls were born and proceeding with illustrations of successive stages of their development. She suggests that with more research on development in the years beyond childhood and adolescence "child development may be more clearly seen in its proper perspective as one phase of human development."

QUESTIONS PARENTS ASK. James Lee Ellenwood. E. P. Dutton & Co., New York. 1955. 155 pp. $2.50.

After discussing the questions of hundreds of parents the author brings up one that he thinks parents should ask themselves: "What do we hope for our youngsters, anyway?" He lists possible objectives as: sound physical health, mental alertness, conscientiousness, and social acceptability, and calls the quality of conscientiousness "perhaps the most desirable of all traits, setting our standards and determining the pattern of our living."

COUNSELING WITH YOUNG PEOPLE. C. Eugene Morris. Association Press, New York. 1954. 144 pp. $3.

Designed to help volunteer leaders of youth groups to advise members who turn to them for help, this book offers suggestions to anyone who serves as such a leader in a social-work, recreation, religious, or youth-serving organization. It discriminates between areas in which such leaders can be helpful and those which call for referral to professional services.

THE STORY OF NURSING. Bertha S. Dodge. Little, Brown & Co. New York. 1954. 237 pp. $3.

Addressed to girls thinking of entering nursing school, this book tells the history of the nursing profession.

THE ART OF CHILD PLACEMENT. Jean Charnley. Introduction by Dorothy Hutchinson. University of Minnesota Press, Minneapolis. 1955. 265 pp. $4.50.

This book urges that foster placement be considered not merely a resource to be used only when all else has failed, but rather as a tool "to prevent total destruction of what is healthy and sound in a shaky family situation."

It discusses placement of very young children; establishment of relationships between the social worker and the older child who is not yet adolescent; values of the foster home and of the institution; and casework with "own" parents, with foster families, and with adolescents.

YOU AND YOUR RETARDED CHILD; a manual for parents of retarded children. Samuel A. Kirk, Ph.D.; Merle B. Karnes, Ed. D.; Winifred D. Kirk, M. S. Macmillan Co., New York. 1955. 184 pp. $4.

The authors address this book to parents of retarded children; to doctors, psychologists, social workers, and educators, who are frequently called on to advise these parents; and to relatives and friends of families with retarded children. Chapters include, among other subjects, a discussion of normal stages of development as a measuring rod for retardation, and ways of helping retarded children to become more independent, to play, to learn to talk and to control their behavior.

TWO LEGS TO STAND ON. John D. McKee. Appleton-Century-Crofts, Inc., New York. 1955. 180 pp. $2.75.

Now over 30 years old, the author tells how he has conquered a large part of the handicap of cerebral palsy. He completed 4 years of college at a distance from his home. He earns his living. He can swim and drive a car. His parents, especially his mother, are credited with teaching him—urging him—to learn to be independent.

HELPING YOUR CHILD'S EMOTIONAL GROWTH. Anna W. M. Wolf and Suzanne Szasz. Introduction by Milton J. E. Senn, M. D. Doubleday & Co., Garden City, N. Y. 1954. 305 pp. $5.

More space is given in this book to pictures than to words, as the author and the photographer present common life situations involving parents and children. Much of the content is focused on "certain important moments in a child's life that are harder for him than others, and times when he may need your special help and understanding to enable him to go forward and take the next step in healthy, happy development."

THE ONLY CHILD; a guide for parents and only children of all ages. Norma E. Cutts and Nicholas Moseley. G. P. Putnam's Sons, New York. 1954. 245 pp. $3.50.

After studying the histories of more than 250 persons, each of whom was an only child, the authors of this book offer advice to parents on helping an only child to develop a healthy personality. They say: "The problems which an only child faces are essentially those faced by all human beings. Onliness is at most a complicating factor."

PERINATAL MORTALITY IN NEW YORK CITY; responsible factors. Analyzed and reported by Schuyler G. Kohl, M. S., M. D., Dr. P. H. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass. 1955. 122 pp. $2.50.

The second and final phase of an intensive study of infant mortality in New York City is reported in this volume, which presents an analysis of the clinical records of 955 babies and their mothers. All the babies had been stillborn or had died at birth or within a month afterward. In the opinion of a subcommittee of the New York Academy of Medicine's committee on public-health relations, which studied the cases, 35 percent of the deaths were preventable.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

A LONG TIME TO GROW, Part 2. (Studies in Normal Personality Development Series.) 35 minutes, sound, black and white, purchase or rent.

Shows development of children 4 and 5 years, old, with flashbacks to earlier ages to suggest the gradual nature of changes in the child as he grows older. (Part 1, noted in CHILDREN, September–October 1954, was concerned with children from 2 to 3.)

Audience: Students preparing for professional fields concerned with children; parents, general public.

Produced by: Department of Child Study, Vassar College.

Distributed by: New York University Library, 26 University Place, New York 3, N. Y.

WHAT ABOUT JUVENILE DELINQUENCY? 11 minutes, sound, black and white, purchase.

Points to the complexity of the juvenile-delinquency problem in a high-school group.

Audience: Community groups.

Produced by: Young America Films, Inc., 18 East 41 Street, New York 17, N. Y.

Distributed by: Same.

GETTING ALONG WITH PARENTS. 14 minutes, sound, black and white or color, purchase.

Presents both sides of an apparent impasse between a group of teen-agers and their parents over a class dance. The parents of one of the young people work out a plan successfully with the other parents and the teen-agers. Suggests the value of family discussion of mutual problems.

Audience: Parents; teen-agers.

Produced by: Encyclopaedia Britannica Films, Wilmette, Ill.

JOHNNY'S NEW WORLD. 16 minutes, sound, color, purchase or rent.

Offers an example of a boy whose failing eyesight is interfering with his school success. When his teacher discovers his trouble, she joins with the school nurse to refer him to an eye specialist. The film also takes up the problem of crossed eyes.

Audience: Parents.

Produced by: National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Distributed by: Same.

CHILDREN WITH NEPHROSIS. 12 minutes, sound, color, loan.

Indicates various stages of treatment for children with the serious kidney disease called nephrosis.

Audience: Students preparing for the medical and related professions.

Produced by: Campus Film Production.

Distributed by: National Nephrosis Foundation, 143 East 35th Street, New York 16, N. Y.; and Pfizer Laboratories, Film Library, 630 Flushing Avenue, Brooklyn 6, N. Y.

A companion film, "Nephrosis in Children," may be borrowed by physicians.

RETURN TO LIFE. 23 minutes, sound, color, purchase or loan.

Shows how handicapped children are served under a State crippled children's program, especially those with a congenital heart condition requiring surgery.

Audience: Parents of handicapped children.

Produced by: University of Illinois, Division of Services for Crippled Children, 1105 South Sixth Street, Springfield, Ill.

Distributed by: Same.

MOTHERS OF ACARI. 10 minutes, sound, black and white, loan.

Shows how a maternal- and child-health clinic was established in a small town in the interior of Brazil. The project was started through local efforts. Then the Brazilian Government provided a building, and UNICEF equipped it and trained a local young woman as a midwife.

Audience: Professional and lay groups.

Produced by: United Nations Department of Public Information.

Distributed by: Same.

THREE TO MAKE READY. 45 minutes, sound, black and white or color, purchase or rent.

Illustrates the efforts of specialized workers to rehabilitate patients: a 5-year-old boy with paralyzed legs; a 20-year-old cerebral-palsied girl, severely handicapped; and a 48-year-old widower, crippled by an industrial accident, who is the father of two boys.

Audience: General public, especially community groups contemplating the possibility of setting up a rehabilitation center.

Produced by: Institute for the Crippled and Disabled, 400 First Avenue, New York 10, N. Y.

Distributed by: Same.

YOUR CHILDREN WALKING. 20 minutes, sound, black and white, purchase.

Shows X-ray views of children's feet in motion. Makes clear the importance of good habits of walking, of proper footwear, and of general good care of the feet.

Audience: Parents and professional workers concerned with the care of young children.

Produced by: British Information Service.

Distributed by: McGraw-Hill Book Co., Text Film Department, 350 West 42d Street, New York 36, N. Y.

FROM SOCIABLE SIX TO NOISY NINE. 22 minutes, sound, black and white or color, purchase.

Illustrates daily life in a family consisting of father, mother, 6-year-old daughter, and 8- and 9-year-old sons. A narrator comments. This film is one of a series, "Ages and Stages."

Audience: Parents and students preparing for professions in which understanding of child behavior is needed.

Produced by: National Film Board of Canada.

Distributed by: McGraw-Hill Book Co., Text Film Department, 330 West 42d Street, New York 36, N. Y.

PROJECTS AND PROGRESS

Conference on Health and Delinquency

With the holding of a 3-day conference on Health Services and Juvenile Delinquency, in Washington May 19–21, the activities of the Children's Bureau's Special Project on Juvenile Delinquency came to an end. Set up 3 years ago and supported by private funds, the project helped States and local communities in efforts to prevent and treat juvenile delinquency. Its functions will be carried on by the Bureau's new Division on Juvenile Delinquency Services.

The health conference, last of the project's series of conferences on various phases of delinquency prevention, was attended by 77 doctors, nurses, medical social workers, and representatives of other professions in health services from 25 States. Called together to consider the role in combating dissocial behavior of "all persons who offer health service whether by private or public means," the conferees focused on the mental-health contribution of health personnel who had not had specialized training in this field.

After an opening session the conferees divided into four work groups to consider this contribution in relation to: (A) maternal and infant care; (B) children from 1 to 5 years old; (C) those from 5 to 12; (D) those 12 and over.

The first two groups pointed out that health personnel have a special opportunity to make a preventive contribution because of their close association with mothers and children at the time the mother's attitude toward the child is first forming, and in the early years of the child's life when the basic elements of his personality are being established. They pointed out that health personnel in prenatal, maternity, and well-child services and obstetricians and pediatricians in private practice especially are in strategic positions to foster the development of good parent-child relations.

Some of the practical steps suggested toward this end were: the provision of basic knowledge about personality development to all health workers so that they might help parents to understand their children and themselves in relation to their children and to learn to cope constructively with behavior problems; the participation by health personnel in efforts to strengthen and extend existing services and to create a health-inducing community environment; cooperation by health personnel with social-work agencies in serving unmarried mothers and their babies so that young children will not be deprived of the care of a mother or mother substitute.

Group C pointed up the responsibility of health personnel to be alert to early signs of maladjustment in children and of taking appropriate action. This, the conferees recognized, might involve instituting treatment, obtaining assistance from other health personnel, or making a referral to another type of service.

Group D concerned itself especially with the aggressive teen-ager or preteen-ager and of ways health personnel might work with him. The conferees suggested that health workers must join other agencies in reaching out to provide needed services to youngsters resistant to service. They especially underscored the responsibility of health personnel for aiding in the treatment of the adjudicated delinquent through cooperation with police, juvenile court, detention center, and training schools.

All the groups recognized that those services which are most effective in prevention are general in nature and not focused solely on the prevention of dissocial behavior—that it is impossible, at our present state of knowledge, to predict definitely the type of personal maladjustment that will result from maternal deprivation, poor parent-child relationships, environmental factors, or other personality-distorting conditions.

A full report of the conference, with the discussions reorganized under topical headings, will soon be available.

—Bertram M. Beck

Unmarried Mothers

Today as a rule the unmarried mother is willing and anxious to make careful plans for her child, and this is one of the most heartening developments in this field, according to a 51-page report published recently by a committee of the National Conference of Catholic Charities. The report carries information from 43 Catholic maternity homes in 22 States and the District of Columbia. These homes have facilities for more than a thousand mothers, and, in the 30 with nurseries, for nearly two thousand babies.

Noting that casework is the cornerstone of the program, the committee reports that all the 43 homes make some provision for this service before the mother enters the home and during her stay, and all but 11 provide it afterward. Nearly all the homes provide prenatal and postnatal care and medical emergency care; the rest use local hospitals for these purposes. Only 10 refer the mothers to hospitals for delivery. More than half the homes have salaried pediatricians on the staff or on call; somewhat less than half have pediatricians who donate their services. Nearly all the homes have recreational activities, but only one has a groupwork program as such.

The report notes as a good development the establishment of group homes, housing only six girls, with a minimum of rules, where freedom and responsibility are encouraged.

The unmarried mother's need of understanding, affection, and acceptance is stressed throughout the report. Especially it urges the importance of not taking a punitive attitude toward her.

Copies are available at $1.25 from the Conference, 1346 Connecticut Avenue, NW., Washington 6, D. C.

Juvenile Delinquency

New York City's Community Service Society recently recommended to a State commission that a citywide youth court be created to take the place of the many courts and court divisions now handling youth cases.

The proposed court would be part of a comprehensive family court, previously proposed by the society, to have jurisdiction over all court cases involving problems concerning children, young people, and families.

The society's plan would make noncriminal proceedings mandatory for all defendants over 16 but not yet 21, except those charged with homicide or those 19 or over who have committed certain other felonies. Under noncriminal proceedings the defendant is not charged with a crime, but with being a "youthful offender," and is detained separately from older defendants. If guilty he is not given a criminal record. The courts now may hold such proceedings at their discretion, but only for youths under 19.

The society proposed that if a minor pleads not guilty to being a youthful offender he will have the right to trial by jury unless he specifically waives it. It also proposed that: before ordering a plan for treatment the court have a study made of the youth's "nature and circumstances"; those responsible for the study submit a recommendation for disposition of the case; reasons be placed on record when other than the recommended disposition is made.

Copies of the 154-page report, "Justice for Youth; the courts for wayward youth in New York City," may be had from the Society, 195 East 22d Street, New York 10, N. Y. Price $1.

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Thirty proposals for research resulted from a conference on psychiatric research in regard to juvenile delinquency held in Princeton, N. J., last spring, under the sponsorship of the Welfare and Health Council of New York City with support from the Edward L. Bernays Foundation, Inc.

The suggested studies fall into six general areas: personality traits and characteristics including possible constitutional factors which predominate among delinquents; group dynamics and the causes of group conflicts; environmental studies conducted by interdisciplinary teams of psychiatrists, sociologists, and statisticians; social pathology as a causal factor in disorder among young people; interaction between personality, environment, and culture and its effect in producing delinquency; normal development and maturation as a norm for recognizing deviation.

Such studies, the conferees suggested, should be undertaken in "the laboratory of life"—the home and family, the clinic and hospital, the school and playground, the neighborhood and larger community, and the social agency. Recognizing that solution of the serious problem of retention and recruitment of personnel is vital to any research or operational program, they also recommended research into the characteristics of the effective "therapeutic" personality.

The conference was first in a series on various aspects of research in delinquency planned by the Council. The 27 persons attending were nationally known specialists in child development, psychiatry, research, welfare, and health.

A full report of the conference is available from the Welfare and Health Council, 44 East 23d Street, New York.

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Late in July the Senate, by resolution authorized its Judiciary Committee's Subcommittee To Investigate Juvenile Delinquency to continue to January 31, 1956. Given an additional $125,000 by Congress in March 1955 plus $29,000 in July to pursue studies of juvenile delinquency, the subcommittee is conducting hearings on various aspects of the problem, such as how lack of suitable employment opportunities for young people contributes to delinquency and what effect pornographic materials have on youth behavior. It is also concerned over the black market in babies. (See column 3.)

Trachoma

In an effort to discover a safe vaccine that will prevent trachoma, the Harvard School of Public Health and the Arabian American Oil Company recently began a 5-year $500,000 research program. Previous efforts to control this widespread and often blinding eye disease have been focused mainly on finding a cure.

Though the new research program will be directed primarily toward the development of a vaccine, it will also involve other aspects of trachoma control—medical treatment; the elimination of possible transmission agents, such as insects and insanitary conditions; and efforts to build up resistance to infection in exposed persons. It will also be concerned with the control of other types of eye infection.

Migrants

New York State's new regulations to improve living conditions at farm-labor camps specify minimum standards that must be met before any person may operate such a camp. Each camp operator must obtain a permit each year from the full-time local health officer, who is responsible for ascertaining that living conditions at the camp meet the detailed standards set by the regulations. Previously standards for such camps were covered only in general terms in the State sanitary code.

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Even more local than migrant children under 16 are employed in agriculture during school hours according to the U. S. Department of Labor. Members of the Department's staff investigating such employment, which violates child-labor provisions of the Fair Labor Standards Act, found that in 3 successive fiscal years—1953, 1954, and the first 6 months of 1955—local children represented 57 percent, 60 percent, and 56 percent, respectively, of the total.

Adoption

A number of adoption agencies in the San Francisco Bay area, public and private, along with two organizations specifically concerned with minority-group problems, are beginning a joint 3-year project to find adoptive homes for Negro and Latin-American children. The committee responsible for formulating policy is known as MARCH which stands for Minority Adoption Recruitment Committee for Homes. The Columbia Foundation has granted funds to support the first year's activities.

The program is part of a widespread effort to recruit foster-family homes, including adoptive homes, which the National Urban League is developing in various cities.

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Testimony on a black market in babies occupied 2 of the 3 days of hearings held in Chicago in mid-July by the Subcommittee to Investigate Juvenile Delinquency of the Senate Judiciary Committee. Witnesses told of activities involving the sale of babies that had occurred in Chicago, in Oklahoma, and Texas, and in a New York-focused traffic from Montreal, Florida, and Massachusetts.

Senator Estes Kefauver (Tenn.) served as chairman of the hearings, which were attended also by Senators Edward J. Thye (Minn.) and William Langer (N. Dak.).

Two representatives of the Children's Bureau, Mildred Arnold, director of the Division of Social Services, and Margaret Thornhill, special consultant, were called on to comment on the kinds of services neded for sound adoption placement and conditions that force unmarried mothers to turn to independent arrangements. Sound placement, they emphasized, involves: getting to the unmarried mother as early as possible; providing her with the kind of social service that can help her arrive at an early and firm decision on whether or not to give up her child; the use of social service in the selection and supervision of adoptive homes; the provision of good medical care for mother and child; good legal machinery for the relinquishment of the child by its natural mother.

Community services and facilities need to be greatly increased and the mother's confidence respected if placements through individuals are to be avoided, the Children's Bureau representatives said.

Research in Prostheses

A university research project on prosthetic appliances for adults who have lost an arm or a hand was recently broadened to include children under the State crippled children's program. California's State department of public health has joined the University of California at Los Angeles in this work to determine (1) what kinds of prosthetic appliances are best suited for young children; (2) how early children with congenital amputations can be successfully fitted with such appliances; (3) what kinds of training will enable the children to make the best use of them.

Each child accepted is studied at the Marion Davies Pediatric Center by a team consisting of an orthopedic surgeon, a pediatrician, a psychologist, a social worker, an occupational therapist, and a prosthetist, all on the staff of the university's departments of medicine and engineering. On the basis of this study, children are referred to the university's engineering department for the prescription and fitting of a suitable prosthetic appliance. The child and his parent live near the university for 2 to 4 weeks so that they can be trained in the use of the device. Later they return for followup visits at intervals of 3 to 6 months, as long as these are necessary.

Medical Care

Nearly a million and a half children now have some medical care available to them through the aid to dependent children program under the Social Security Act, according to the office of the Commissioner of Social Security, Department of Health, Education, and Welfare. All but 9 States provide financially for some medical care for children through this program. In some States the care provided is comprehensive; in others it is relatively slight.

Under the act, the State public-welfare agency may use either or both of two methods of paying for medical care to families receiving funds through ADC or any of the other federally aided assistance programs. By one method, the agency includes amount to pay for such care in the money payments to the families. By the other it makes direct "vendor payments" to doctors, hospitals, and others providing the care.

In the 22 States reporting on vendor payments in ADC in January 1955, the average monthly payment per family ranged from $17 to less than 1 cent.

During the fiscal year 1954 vendor payments for medical care for families receiving aid to dependent children amounted to $15,600,000 of State and Federal ADC funds, plus $1,600,000 of general-assistance funds from State and local sources.

Additional amounts for medical care, provided as part of the money payments to families, raised the total medical-care expenditures in ADC to a probable $26,000,000, an average of $3.70 per family per month, and 4.6 percent of the total assistance expenditures under the ADC program.

Eye Clinics

The New York City Department of Health recently made an analysis of the costs and operations of the 23 eye clinics operated as part of its services to crippled children. It found that the 30,794 individual children seen in the clinic during 1954 cost the department $3.22 per child per year for clinic personnel and $1.71 per clinic visit. An average of 11 children were examined in each 3-hour ophthalmological session.

Of the 29,429 ophthalmological diagnoses made, refractive error occurred most frequently, accounting for 88.4 percent. Strabismus, or squint, accounted for 8.3 percent; "diseases and defects," including infections, for 2.5 percent; and developmental anomalies for 0.8 percent. Sixty percent of the children with refractive errors were suffering from myopia, or nearsightedness; 40 percent from hyperopia, or farsightedness.

Ninety percent of the children were referred to the clinics as a result of school screening tests in which they failed to read 20/40 on a Snellen chart. Only 1.6 percent were preschool children referred by child-health stations or day-care centers, a fact which the department attributes to the lack of a preschool vision program in the community.

One serious problem revealed in the analysis was the high rate of broken appointments. While 58,000 visits were made to the clinic, 38,283 others had been scheduled but unkept.

Child Welfare

A followup study to evaluate the work of a children's reception center in Kent County, England has shown "fairly conspicuous improvement" among more than half of 200 children for whom the center's staff had recommended various types of care to the county welfare department.

Material for the study was gathered through personal study of 100 children by a psychiatrist and a psychiatric social worker and through inquiries by correspondence concerning 140. The former involved home visits and included interviews with the children and with mothers, foster mothers, teachers, and welfare workers.

While not all the children showed improvement, the proportion in good psychological and social condition had more than doubled. Sixty-three percent had improved; 29 percent had not changed; 8 percent were worse.

Study centers for children are now required by act of Parliament in all counties. The one in Kent County, however, financed by the Nuffield Foundation, was established before the act was passed.

The story will not be complete until the children have grown up and have become citizens and parents, says Hilda Lewis, the psychiatrist, in her report, "Deprived Children; the Mersham experiment, a social and clinical study," published by Oxford University Press, New York.

* * *

North Carolina's county departments of public welfare provided services other than financial to nearly 50,000 families during the fiscal year ended

June 30, 1954. The largest proportion of the services, 36 percent, were direct services to individual children. Other nonfinancial child-welfare services were provided: to families adopting children (5 percent); in cases of nonsupport of children (4 percent); and for finding, licensing, and supervising foster homes (3 percent).

Sixty-two percent of the families receiving such services were white, 37 percent, Negro, and less than 1 percent. Indian.

Facts and Figures

Although the urban and rural populations of the United States are growing at approximately the same rate, the number of children under 15 is increasing faster in urban than in rural areas, according to the Bureau of the Census, Department of Commerce. Between April 1950 and April 1954 the rural population as a whole increased by 6.3 percent; the urban by 5.6 percent. During the same period the number of children under 15 in urban areas rose by 17.9 percent (from 23,400,000 to 27,600,000); and the number in rural areas by 12 percent (from 17,100,000 to 19,200,000). The gain of 4,200,000 in the child population of urban areas accounted for three-fourths of their total increase in population. The 2,100,000 gain among rural children accounted for three-fifths of the total rural-population increase.

. . .

School enrollment in rural areas has increased since the child-labor provisions of the Fair Labor Standards Act were amended to prohibit employment of children under 15 in agriculture during school hours. Between 1951, the year after the amendment became effective, and 1954, enrollment of rural children 10 through 15 years rose from 94 percent to 97 percent. Enrollment of urban children in the same age group remained stationary at 99 percent.

. . .

Of the estimated 4,067,000 births in 1954 in the United States, about 300,000 (7.6 percent) were premature. No information is yet available on the deaths of premature infants in 1954; but in 1952 deaths of such infants represented about 57.5 percent of all deaths in the first 4 weeks of life and 41 percent of all deaths in the first year.

Infant deaths were 2,000 fewer in 1954 than in 1953, though 112,000 more babies were born in 1954. The infant mortality rate for each month of 1954 was lower than the rate for that month in any earlier year. For the entire year, there were 26.8 deaths of infants under 1 year for every 1,000 live births, the lowest national annual rate so far recorded. Data for individual States are not yet available.

. . .

Divorces in the United States in 1953 amounted to 390,000. The figure is far below the peak reached in 1946, when 613,000 divorces were granted.

. . .

National per capita income continues to increase. For the United States as a whole, the per capita annual income was $1,709 in 1953, an increase of 4 percent over the figure for 1952. In 1953, for the richest State, Delaware, it was $2,304; for the poorest, Mississippi, it was $834.

. . .

Of every 7 children under 18 years in the United States in 1953, 1 was living with only one parent or with neither parent. About 4,700,000 children were living with one parent, usually the mother, and 2,400,000 with neither parent. Of the latter group 1,700,000 were with relatives, and 700,000 were in foster-family homes or institutions or were living alone. The total number living with only one parent or neither was 7,000,000.

. . .

Births out of wedlock totaled 150,300 in 1952, the latest year for which figures are available. This was 68 percent greater than the number in 1940, and probably represents an all-time peak. In 12 years the rate of such births per 1,000 unmarried females more than doubled, going from 7.1 in 1940 to 15.2 in 1952. Except for 1948, births out of wedlock have increased each year since 1940.

. . .

Of the 1,500 people who die each year through accidental poisoning, more than 20 percent are children between the ages of 1 and 4 years of age.

Here and There

A 3-year study to learn how orthopedically handicapped children and youth can participate in group-work and camping activities is beginning under the supervision of the Welfare and Health Council of New York City. The project, which will be largely supported by a grant from the Association for the Aid of Crippled Children, will involve a total of about 180 children and will have a distinct research aspect.

. . .

The Women's Adoption International Fund, known as WAIF, originally organized by the Hollywood movie colony to bring homeless children from abroad to this country for adoption, has become a fund-raising branch of International Social Service, Inc. Its first drive for funds got underway last summer.

. . .

A committee to examine all Travelers Aid Services to Children was formed recently by the National Travelers Aid Association. Establishment of the committee is an outgrowth of the work of the Association's committee on children traveling alone.

. . .

Baltimore's City Health Department recently issued a "Handbook of Vital Records Information for Attorneys and Welfare Workers." It explains practices of the department's vital-records office, with special attention to alteration of birth certificates in cases of adoption, legitimation, adjudication of paternity, and legal change of name.

. . .

To finance a 3-year survey of the value and effectiveness of school health services in the city of New York, the Public Health Service, United States Department of Health, Education, and Welfare, has granted $159,940 to the Welfare and Health Council of New York City.

. . .

Mental Health Materials Center, Inc., by arrangement with the Canadian Government, recently brought out a United States edition of seven leaflets on child training produced by Canada's Department of Health and Welfare, Ottawa. The titles are: Lying and Stealing; Discipline; Obedience; Sex; Temper; Destructiveness; and Preparing Your Child for School. Prices and other information from the Center, 1790 Broadway, New York 19, N. Y.

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READERS' EXCHANGE

CIANCI: ***Residences for the retarded***

I was delighted with Vincentz Cianci's "Home Training for the Mentally Retarded Child," (CHILDREN, May–June 1955), particularly with her emphasis on the need for residential care. As a founder of and parent-leader and writer-volunteer for the National Association for Retarded Children I have become concerned about the place of the institution in a total program for the retarded. In the effort to press for intermediate facilities between total home care and total institutional care, the inclusion of residence centers in the total community planning picture has sometimes been lost.

Placement outside the home is often essential for many reasons—the severity of the child's handicap; death or poor physical or mental health among other members of the family; lack of community facilities in sparsely settled areas; and lack of community acceptance in areas not so sparsely settled.

We must strive to make our residence centers more homelike and constructive (through training programs) and reasonably accessible so that parents can keep the institutionalized child within the sheltering arms of his own family.

Letha L. Patterson
Board member, National Association for Retarded Children, Stillwater, Minn.

ROBINSON: ***Data-sharing needed***

In referring to the current research by Community Research Associates Marion Robinson states: ". . . the potential gains which may accrue from the experiment . . . may be enormous but are as yet unpredictable." ("A Team Approach in Preventing Maladjustment," CHILDREN, March-April 1955.) Indeed, the contribution may be enormous, but it will not and cannot reach its potential if the publication pattern of Community Research Associates continues as at present, with seeming oblivion of the absolute necessity to reveal *theoretical structure, hypotheses, methods, and findings* as well as conclusions and recommendations.

Judged in terms of its performance to date, Community Research Associates has failed to recognize or make evident its recognition of some fundamental prerequisites in the development of knowledge.

Scientific knowledge and the use of such knowledge must be dependent upon the accretion process. Without the possibility of building upon the accomplishments and failures of the past, science and professional practice remain limited to the capability of the single individual or single organization.

In the development of a scientific base for social-work practice the traditional procedures of accretion of knowledge have generally been followed. This has included the publication of research procedures and findings, practitioners' insights and observations, theoretical and philosophical formulations. As a field we have, at times, however, failed to remember that the methods we follow, the tools we use in obtaining information are all important contributions in themselves and always an inseparable part of the findings and conclusions we report. When reported they become not only possible tools for further research but also indispensable clues to the merit of data and conclusions they have served to elicit.

Community Research Associates, the most affluent single social-work research organization in this country, restricts the release of basic data in such a manner that it is neither prudent to use its findings and conclusions nor possible to build upon its methodological advances. Clearly, the St. Paul study, the current studies in Hagerstown, Md., Winona, Minn., and San Mateo, Calif., the project on classification of family disorders, all have great *potential* usefulness to the field of social work. However, if the pattern of partial and inadequate release of research material established with the publication of *Community Planning for Human Services,* (Bradley Buell and Associates, Columbia University Press, New York 1952) is continued, the actual usefulness of the published material will remain limited.

There are indications that it is destined to continue. In discussing the research design and methodology of a project on classification of family disorders, at a meeting of the New York Social Work Research Group last winter, a staff member of Community Research Associates indicated that certain data on methodology, findings, and conclusions, already in printed form, were available neither to the social-work profession as a whole nor to the public because "they might be misinterpreted."

It is hoped that Community Research Associates will continue to thrive and to contribute to the growing supply of social work knowledge. It is also hoped that this organization, along with all of us in social-work research and social-welfare planning, will learn the value and absolute necessity of improved communication in research ideas, practices, and findings, in order to permit the critical evaluation and possible extension and enhancement by the field as a whole of the contributions of every individual and organization.

Martin Wolins
Associate Director, Institutional Cost Study, Child Welfare League of America

[Editor's note: A letter from Bradley Buell, director of Community Research Associates, will appear in the November-December issue of CHILDREN in response to Mr. Wolins.]

FOSTER: ***Responsibility for prevention***

It is refreshing to read in Katharine Foster's article ("Stabilizing Influences in Helping Handicapped Children," by Katharine L. Foster, CHILDREN, March-April 1955), of the philosophy of the staff members of the Massachusetts Hospital School for Crippled Children to "never give up, while a child is under care, the efforts to seek out and build on the stabilizing factors which can sustain his future." Too often social workers, as well as other professional personnel having responsibility for the rehabilitation of an individual child, concern themselves solely with the very personal relationship between one professional staff member and the child. Too often, also, we may ignore the many other forces within the child's own family group as well as within the wider environment of his total community which could be utilized as positive factors in the attainment of the goals of rehabilitation.

As Miss Foster points out there is also an imperative need for social workers and other personnel to accept their responsibility in the field of prevention. A supportive relationship to an individual at crisis periods in his life may produce lasting changes in that individual.

Margaret G. Holden
Supervisor, Medical Social Training Project, Division of Services for Crippled Children, University of Illinois

de ZAYAS: *Nutrition education, an art*

The effects of coordination and cooperation rather than competition between existing agencies are well demonstrated in Dr. de Zayas' description of the Puerto Rican nutrition program ("Better Nutrition for Puerto Ricans," by Esther Seijo de Zayas, CHILDREN, March–April 1955.) One senses that the Nutrition Committee did not feel that *their* plans were the only, or even the best, solution to the pressing health problems that arise from any environment in which the available quantity and quality of food are inadequate to meet human needs.

The development of the Basic Four poster was a realistic acknowledgement of the foods available and preferred, and its basic philosophy is of help to workers in other countries as well as in Puerto Rico. . . .

The feeding programs described are so extensive as to give the Nutrition Committee a real means of evaluating their demonstration techniques. Nutritionists on the mainland remember sadly that during the depression, nutrition education tried to "run" but could not begin to "catch up" with the needs of those to whom surplus food was distributed. I recall finding a woman cooking a grapefruit and remarking that "it didn't get done!"

Disbursement of foods is an administrative technique; nutrition education is an art and a science that requires that we evaluate our efforts in the terms of the health of the people.

Only the years will prove the answer now sought by all workers who are attempting to develop nutrition programs which meet the total needs of the people they serve.

Adelia M. Beeuwkes
Associate Professor of Public Health Nutrition, School of Public Health, University of Michigan

A lesson for the mainland

Puerto Rico's nutrition program as described by Esther Seijo de Zayas might well be emulated by many a health department on the mainland, particularly in regard to the following features:

1. Basing the program on "real" needs as shown by dietary intake and health-status data, such as selected mortality and morbidity statistics.

In many health programs the latter data are ignored as an indication of nutritional needs simply because they do not show poor nutrition as the *sole* cause of death or illness.

(I would however, question the validity, as an indication of nutritional status, of a comparison of height-weight data for children in Puerto Rico with children on the mainland, unless the comparison is made between children with similar hereditary background.)

2. Planning the nutrition work as part of a total health program.

To facilitate such planning, nutrition personnel must be administratively so placed in a health department that their services can be made readily available to all other divisions or bureaus—an achievement made possible in Puerto Rico through creation of the Bureau of Nutrition and Dietetics.

3. The inclusion of many agencies and many disciplines in the program.

4. Positive recognition of the attitudes and cultural values of the population.

Ruth L. Huenemann
Associate Professor of Nutrition, School of Public Health, University of California, Berkeley

FOR YOUR NOTEBOOK

☛ In 1954, for the third consecutive year, marriages dropped below 10 per thousand population. The rate for 1954 was 9.2, the lowest since 1933. Decline in marriages in recent years has generally been attributed, says the National Office of Vital Statistics, Department of Health, Education, and Welfare, to the low birth rates in the 1930's to high marriage rates in 1946–47, and to continued "borrowing" from future marriages through reduction in age at first marriage.

. . .

☛ The proportion of married persons in the population is increasing, according to the Bureau of the Census, Department of Commerce. In 1954 about 69 percent of the adult population were married; in 1940 the percentage was 60. More married couples maintain their own households. The percentage increased from 91.3 in 1947 to 96.1 in 1954.

. . .

☛ Registered live births in the United States, it is estimated, reached an all-time high of 4,021,000 in 1954. This is 2.9 percent more than the number in 1953. The year 1954 becomes the fourth successive record-breaking year. The birth rate per 1,000 population was 25.0 in 1954; it was 24.7 in 1953.

. . .

☛ Elementary school enrollment has increased about 19 percent, and kindergarten enrollment some 67 percent, since 1950, according to the Bureau of the Census, Department of Commerce. The number of children enrolling in elementary schools rose from 20,501,000 for the school year 1950–51 to 24,427,000 in 1954–55. Kindergarten enrollment went up from 902,000 to 1,509,000. Schools below the ninth grade have had to accommodate 4.5 million more children in the last 4 years.

High-school enrollment (grades 9 to 12) has grown 16 percent since 1950. From 6.7 million in 1950–51, the number of these pupils rose to 7.7 million for the 1954–55 school year.

. . .

☛ Nearly 400,000 nurses—an increase of 16,000 since 1950—are now working in the United States, according to the Public Health Service, Department of Health, Education, and Welfare. National nursing organizations estimate that to provide the nurses needed by the country, 55,000 students should be entering nursing schools each year. In 1954 the schools admitted 44,930 students, the greatest number ever admitted in peacetime.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

NUTRITION AND HEALTHY GROWTH. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. 352. 35 pp. 20 cents.

Addressed to teachers, nurses, social workers, and others who work with parents, this pamphlet gives the essentials of good nutrition for the prenatal period, the infant, the preschool child, the school child, and the adolescent.

LEADERSHIP THROUGH CONSULTATION; how a State welfare department builds strength in agencies providing group care for children. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1955. 44 pp. Processed. Single copies from the Children's Bureau without charge.

"An analysis of philosophy, principles, and problems involved in State-agency consultation for institutions and day-care centers" as made in a 3-day conference of public-welfare consultants from Florida, Georgia, Mississippi, and Tennessee with staff members of the Children's Bureau.

THE 7th YEAR OF WORK, INTERDEPARTMENTAL COMMITTEE ON CHILDREN AND YOUTH. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1955. 20 pp. Processed. Single copies from the Children's Bureau without charge.

This annual report for the year ended June 30, 1955, describes the work of a committee that includes representatives of Federal agencies conducting programs that affect children's well-being. It summarizes the year's work, including study of agricultural migrants, juvenile delinquency, mental retardation, and transition from school to work.

ORGANIZATION AND STAFFING FOR FULL-TIME LOCAL HEALTH SERVICES. Clifford H. Greve and Josephine H. Campbell. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 441. 1955. 28 pp. Single copies from the Public Health Service without charge.

This report analyzes the coverage of areas in the United States by full-time local health organizations and the number and types of personnel engaged in local public-health programs as of December 31, 1953. It notes that minimum staffing deficiencies in the 1,389 local health organizations reporting approximated 1,700 physicians, 15,400 nurses, 3,000 sanitation workers, and 2,600 clerical workers.

PUBLICATIONS OF THE CHILDREN'S BUREAU, January 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 28 pp. Single copies available from the Bureau without charge.

Titles in this list include: (1) all publications of the Children's Bureau issued since 1950 that are available for general distribution; (2) earlier publications of the Bureau that are still available and of current value.

DIRECTORY OF STATE AND TERRITORIAL HEALTH AUTHORITIES, 1954. U. S. Department of Health, Education, and Welfare, Public Health Service, Bureau of State Services. PHS. Bull. 75. 1954. 73 pp. 30 cents.

Issued annually, this directory presents information on official State agencies administering health programs. Besides departments of health, the bulletin includes other State agencies such as those concerned with hospital planning and construction, mental hygiene, control of water pollution, and crippled children's services not in health departments.

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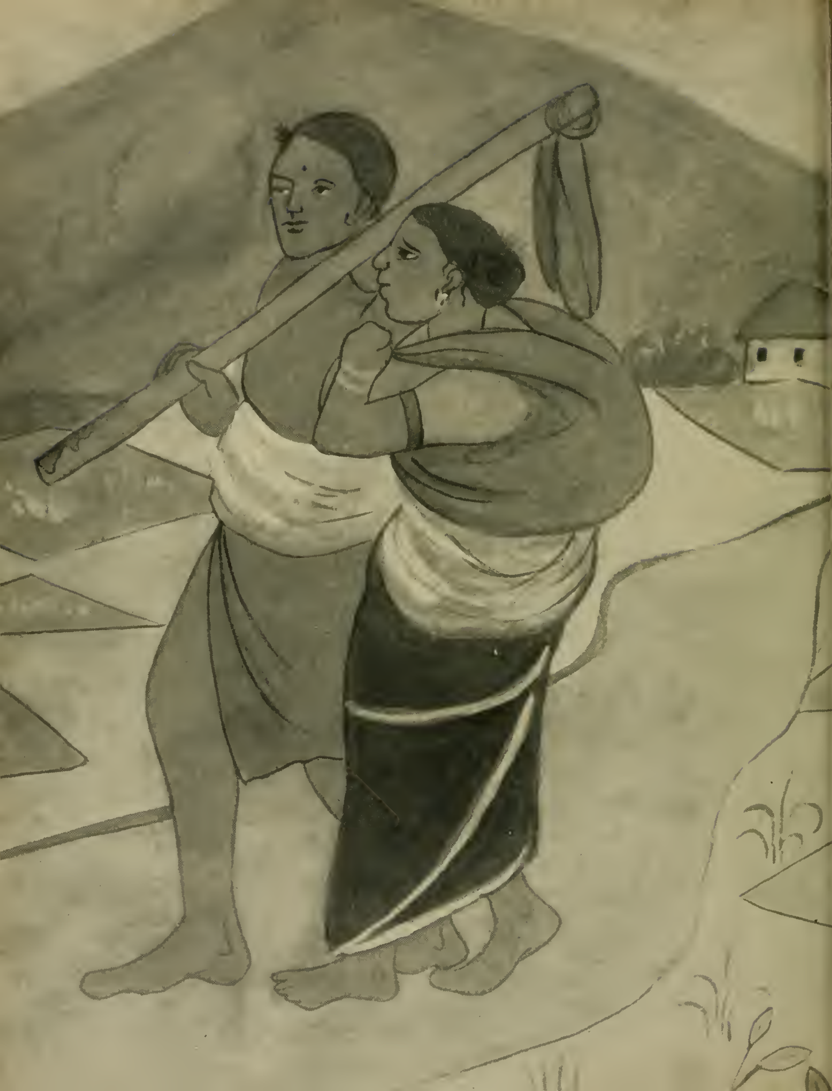
Mental Health for School Children

The Exiled Delinquent

Interagency Communication

Group Work in a Hospital



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the authors

A psychiatrist, who has specialized in child psychiatry, Dr. Warren T. Vaughan joined the staff of the Harvard University School of Public Health in 1948. He was one of the original team at the school's Wellesley project—a community venture in the development of mental-health practice. In his State position, assumed in 1952, he has found a broad opportunity to continue this interest.

Bertram M. Beck, psychiatric social worker and community organizer, directed the Children's Bureau's Special Juvenile Delinquency Project from its beginnings in 1952 until its termination last July. In his present position he will play an important role in helping to launch and steer the new overall organization of social workers, created through the merger of seven professional associations.

"A pediatrician going into maternal and child health and crippled children's work rapidly becomes interested in the 'care and feeding of communities,' and sees interagency communication as a nurture method," says Dr. Pauline Stitt in explanation of her article herein. In the years between her private practice and current university appointment she has been a regional medical director for the Children's Bureau, director of MCH and CC services in Hawaii, and assistant director of the Alameda County Health Department, California.

Constance Impallaria Albee (who added the third part to her name last summer) has traditionally carried her groupwork practice to "untraditional settings." Before beginning her hospital demonstration for the School of Applied Social Sciences, Western Reserve University, she served as group worker on the staff of the Pittsburgh Child Guidance Clinic. She received her social-work training at the School of Social Work, University of Pittsburgh.

Before joining the staff of the Child Welfare League of America, Joseph H. Reid was research director and administrative assistant at the Ryther Child Center at Seattle, Wash. Still concerned over the problems and possibilities of this type of institution, he recently completed a nationwide survey of residential treatment centers with Helen R. Hagan of the League's staff. Mr. Reid received his graduate training at the University of Washington.

Next month Dr. Frank Falkner will come to this country to become assistant professor of pediatrics at the University of Louisville, while continuing to serve as the coordinator of growth studies for the Centre International de l'Enfance. Since finishing his pediatric training in Cincinnati, after basic medical training in London, Dr. Falkner has been lecturer in child health and research assistant at the Institute of Child Health, University of London.

frontispiece

PAINTING by Mukumda Kieshner, age 13, Nepal.

Art, a true international language, can be as expressive among children as adults, as this happy painting of home and parents by a 13-year-old Nepalese child suggests. It is one of the pictures from 100 countries, painted by children from 3 to 17 years of age, shown in an international exhibit of children's pictures which had its world premiere in New York last summer. Previews of some of them had been held in Philadelphia and Washington in 1953 and 1954.

Gathered together by D. Roy Miller of Philadelphia through the countries' ministries of education, the exhibit will be made available in whole or in part to communities throughout the world if sponsorship for carrying it as a permanent mobile exhibit can be found. Purpose of the project, in the words of its creator, is to help "build liveable world understanding among children."

MENTAL HEALTH FOR SCHOOL CHILDREN

WARREN T. VAUGHAN, JR., M. D.

Director, Division of Mental Hygiene, Massachusetts Department of Mental Health, and Assistant Professor of Mental Health, Harvard University School of Public Health

A SCHOOL mental-health program must be concerned with the individual emotional and physical well-being of all the children and adults making up the school community. Its concern then, from an operational point of view, is not only with specific individuals but with *all* of the human relations and other practices which, in fact, may foster individual mental health. This means that practice of mental health is everybody's business and not the prerogative of specialists in clinical psychiatry. In the school situation, teachers, administrators, nurses, custodians, and school children practice mental health and are on the "mental-health team" no matter how informal the team may be, or how formalized it becomes through the introduction of seminars, human relations classes, and so forth.

In Massachusetts, the Division of Mental Hygiene, as part of a statewide program for mental health for school children, is developing area mental-health centers. These work closely with the public schools in programs of mental-health promotion, mental-health consultation, and mental-health screening. The specific function of diagnosis and treatment is kept in the mental-health center to which the schools refer particular children and their parents.

Public health is concerned with communities, groups of people. Therefore, our program includes a broad promotional program aimed at giving community groups general and specific knowledge about human relations and mental health. For this we employ health-education techniques including the use both of mass media and of small group discussions among teachers and parents.

The second and most important part of our school mental-health program is what we refer to as specific prevention of emotional disorders through the use of mental-health consultation. This represents a systematic development of consultation relationships with key individuals in social systems concerned with growing children. These key persons are encouraged to call upon our mental-health consultants for help in dealing with problems of children. Crisis-oriented, the consultation is concerned first with the key person and his effective playing of his role vis-a-vis the child and, secondly, with the clinical appraisal of the child or children involved.

The consultation work is carried on primarily in public-school settings with the classroom teacher as the consultee, but services are also being developed in other community settings, such as courts and probation offices, public and private social agencies and public-health units. The consultant is concerned with children who are maladapted to the social environment, who are reacting to stresses, and who may be further decompensated if relief of tension in their interpersonal relations is not forthcoming. Currently the Division has 23 psychiatrists, psycholo-

States and communities have various viewpoints, reflected in policy and practice, on where the responsibility lies or should lie for providing mental health protection to school-age children and what it should involve. Massachusetts is one which sees the problem through the broadly focused lens of a public-health viewpoint and is developing a statewide program accordingly. How and why are herein described.

gists, and social workers serving as mental-health consultants on its staff, working out of its 15 area mental-health centers.

Early Diagnosis

The third part of the school mental-health program involves the public-health concept of case finding and early diagnosis. Here the consultant helps the school system to use its own resources in association with those of the community to bring children in need of psychotherapy into therapy programs. The people involved in school-adjustment problems include the parents, the teacher, the school administrators, special school personnel—school nurse, school psychologist, guidance counselors, visiting teachers, attendance officers—and persons representing outside community resources—the family physician, the child-guidance clinic, the family agency, and the like.

Clinical experience shows that many children unable to cope with the demands of the school because of their abnormal ego development end up after several school years with seriously distorted self-images and inferiority feelings. Displacements of hostility, with the habitual use of the school setting to act out against authority and gratify punishment needs, is not an uncommon finding in children's psychiatric clinics.

In Massachusetts in 1951 the average age of children referred to psychiatric clinics was 10. Nevertheless most of them had had long histories of serious emotional disorder stemming from ruptures in human relations in the family or treatment from pathological parents. The school experiences of these children had often served only to complicate their emotional difficulties.

During the first year of operation of the clinical program of the Harvard School of Public Health field program in Wellesley, Mass., the average age of the children referred was also 10 years old. A mental-health consultation program was begun in the public-school system after the first year. By the third year the average age of the child coming into the clinic had dropped from 10 to 6.9 years. The consultation service enabled the clinical service to provide *early* diagnosis and *prompt* treatment.

When the Wellesley demonstration project first began, teachers tended to call on the mental-health consultant only for help in dealing with seriously disturbed children. Gradually, however, as the teachers learned how to use the consultant and as the consultant learned more about the school system, the percentage of children talked about in their interviews who were in need of clinic care dropped to less than 20 percent.

The mental-health consultants are most interested in the primary grades and kindergartens where children are making their initial adjustments to the extrafamilial school setting, where the "unfinished emotional business" of early childhood can be most clearly seen, where the teacher first becomes a key figure in the child's life, and where the teacher and the peer group can be of great help to the child in his emotional growth and development. In these early grades, the consultant, playing his public-health role as case finder, can define psychiatric problems early and bring them to proper resources for definitive study and treatment.

Community Differences

A properly developed mental-health program should help the school in carrying out its functions of giving children a good education in preparation for their life's work and training them for good citizenship. The mental-health service has to be discriminating, however, when dealing with particular communities, since types of organizational and mental-health problems differ from community to community.

In Massachusetts we are working with public-school systems in rural communities, in industrial one-industry towns, in industrial diversified-industry towns, in large cities, and in newly developed suburban communities. The interests and expectations of each community differ in regard to its schools, thus posing different problems for each superintendent. Each superintendent and supervisor differs from the other in his orientation to "mental health." Each school differs in "emotional environment," which is largely determined by the personality, experience, and training of the principal of the school as well as the relationship between the principal and the superintendent of the school system.

Moreover, every school system has a different student-health program, with different degrees of interest and participation by school physicians. Some school systems have nurses working for the board of health while others have their school nursing under the jurisdiction of the school board. This makes considerable difference with respect to how the nurse might function in specific problem situations.

In some communities the teachers are able to enjoy important feelings of achievement because they are able to give the children satisfactions which they lack in their homes. In other communities the teachers feel, with some justification, that they are deprofessionalized and are considered by the parents only one stage higher in social status than nursemaids or governesses. Some school systems have very active, well-developed parent-teacher associations; others regard such organizations with suspicion, refusing to allow them to develop. In some systems teacher status is based on skill and experience, age and length of service, while in others it is based on the grade taught.

These and many other individual characteristics of school systems become important to the school mental-health worker in his efforts to understand the socio-cultural and economic situations as they influence the emotional growth and development of children.

Other Problems

As the mental-health worker begins to interact with the school system, he is faced with many technical problems. One may be the manner in which he is viewed by individual members of the school system. Because he is an "outsider" and not an integral part of the school system, he automatically arouses whatever anxieties may be present in the educator, those arising from personal roots as well as those "institutional anxieties" common within school systems.

The consultant learns very soon always to go to the principal's office when visiting an elementary school. If this call is neglected, anxieties may be aroused in both teacher and principal. In one elementary school where the consultation service was begun by visits to the principal's office, biweekly visits to the school continued for one year before the principal felt secure enough to allow the consultant to meet with the teachers. In another school, the principal farmed the consultant out to various teachers, never feeling free to use him herself until after a parent-teachers meeting where she was reassured of the parents' approval of the periodic presence of the "outsider" in the school building.

The problem of role definition is always before the mental-health consultant. Although his role is to help the teachers' understanding of specific matters pertaining to emotional growth and development, other roles may be ascribed to him—roles properly belonging to the supervisor because they involve judgment and evaluation of the teachers' educational practices. Often the consultant is viewed as someone who will take a problem off the hands of a teacher. He properly avoids the role of social manipulator and does not allow the school administrators to release to him any of the authorities or responsibilities which rightfully belong to the administrator.

Often the school personnel will assume that the consultant will aline himself with one or another school faction. This most commonly occurs in a school where teachers espousing traditional techniques in education are working alongside teachers who are trained in "progressive methods." The mental-health consultant has to use great care and tact in avoiding identification of mental health with either of these schools of educational practice. Children need to develop self-discipline and need to have limits set by adult authority whether in a class taught by progressive or traditional methods.

Frequently the teachers in a school building who first use the consultant are those with personal needs. They sometimes represent a splinter group or faction in the school. This requires the consultant to work carefully with the principal and elementary supervisor from the start in order to avoid having the mental-health program become identified with any particular faction.

Group techniques are often advocated by school authorities as the most efficient way for consultants to meet with teachers. However, group meetings in school systems often look not unlike the classroom situation, with the principal or superintendent playing the role of teacher, and the teachers the role of pupils. If the consultant operates in this way, he is apt to be assigned those roles and value orientations which the teacher group assigns to the administrator. This may affect his consultation with individual teachers, making it impossible for him to deal with the natural conflicts and feelings the teacher may have with respect to administration. Special studies of this problem have been made in the greater Boston area by Dr. Leo Berman [1] through the use of group dynamics. We have used teacher group meetings in our programs very sparingly, although we encourage and participate in the development of credit courses for teachers in the fields of child development and mental health.

In the Community

The school setting represents only one facet of a particular child's life. The home is, of course, central, and is supplemented by the neighborhood and other important community institutions, such as the church and various formal social groups including boys' clubs, Boy and Girl Scouts, Y. M. C. A.'s and the like.

School mental-health problems are actually community mental-health problems. Since a school-health program is concerned with the intimate interactions of various community groups which impinge on the life of the growing child, it can be only one part of a total community mental-health program.

In Massachusetts community mental-health associations have been developed to work along with the professional teams of each of our area mental-health centers. The associations not only give tangible support and direction to the professional operations of the mental-health center, but also assume the important tasks of considering, reviewing, and defining various community mental-health issues and developing action programs for solving them. Their functions are much broader than those of the boards of private child-guidance clinics. They are concerned with every issue which conceivably might influence the mental health of families and children in the community. While they are voluntary organizations, they work on a partnership basis with the State Department of Mental Health in each community.

The State of New York, through its recent legislation, is developing public mental-health boards which carry out functions similar to those of the private associations, as well as some of the functions of the Department of Mental Health in Massachusetts. The medical profession plays a key role in both the Massachusetts and New York plans. In New York, the law requires that the medical profession be heavily represented on each public mental-health board. In Massachusetts the State Department of Mental Health seeks representative medical group approval at every phase in the development of the mental-health program. The medical profession participates in the professional advisory committee of the mental-health association.

Division of Function

The public-school system is a relatively new social institution, grown in the past hundred years into an institutionalized representation of the democratic ideals which are our American heritage. As such it is an important culture bearer, symbolizing what is good, desirable, and essential to our way of life. Its schools are expected by the community to impart those sets of values which the community views as important, whether this is good citizenship or flag waving. The current slogan, "Good schools make good communities," is perhaps more realistic when reversed to read, "Good communities make good schools." While socioeconomic factors and personnel shortages also come into the picture the set of values which is found in a school system, from the pupils and teachers to the administrators and the school board, represents a fair approximation of the values and standards of a community.

Children begin school differing greatly in their readiness for the learning process and for mixing with persons outside their own families. Current knowledge in the field of child development and mental health clearly points to the fact that behavior and achievement of children in school are related within limits of constitutional endowment to: (a) interpersonal relations and emotionally relevant experiences in the child's early preschool life; (b) current emotional crises in the child's family or neighborhood life; and (c) unique personal meanings of the school experience to the child.

This means that the performance of the child in both the social and academic spheres is symptomatic of his mental health and can be understood only in terms of the emotional growth and development of the individual child studied longitudinally in the context of his emotionally relevant human environment. Undesirable performance and behavior on the part of a child must be understood before rational approaches for meeting the problem can be devised.

Mental-hygiene concepts, such as "growth and development" and "emotional maturity," can be introduced into the everyday work of the school personnel—teachers, principals, nurses, guidance people—but they should not be allowed to obscure the key function of the school to develop those sets of values and standards of behavior which the community desires to have in its children. A teacher may have insight and understanding regarding a child's behavior without condoning or tolerating the behavior. The classroom is a classroom in a public community setting. It is not the place for private group therapy. The teacher has many functions but psychotherapy is not one of them.

Psychiatric-treatment functions cannot be properly carried out in school settings, especially since the symptoms which manifest themselves in the school are expressed through clashes with the value system. In many school systems the guidance director is quickly viewed by most teen-agers as the person who "sees the bad boys," although he may have spent years interpreting his function to his colleagues, trying to keep disciplinary problems in the administrator's office and out of his.

The parent who makes a school visit, especially in the lower grades, anxiously asks the teacher "Is my child behaving properly?" or "Is my child doing well in school?" These are proper parental concerns. In fact, their absence in a parent may be symptomatic of some disturbance in understanding or feeling. The interview with a parent in a school setting is completely different from the interview with a parent in a private medical setting, although his underlying concerns may be the same. This is due not to differences in quality of personnel but to the inherent fact that the value-oriented school setting, in which judgments are, quite properly, being made, is not an appropriate one for individual psychiatric investigation.

People reveal, in fact are expected to reveal, private matters in the nonjudgmental medical setting. A child may properly "undress" himself in the clinic. It is inappropriate and symptomatic of disturbance for him to do so in school. He should not be encouraged in such behavior by the school personnel, be it educational, guidance, or health. Guidance personnel are concerned with the ego development and the life adjustment of children in relation to their current and future educational and vocational enterprises, and so, with *how* children are dressed, inasmuch as clothes represent the ego development. They have techniques of interviewing similar to those used in the psychiatric clinics. They may also have the same knowledge as the clinician concerning the instinctual life, or deep motivation. However, in the school setting this knowledge should be put to use in the area of ego strengthening and development, not psychotherapy.

In the area mental-health centers in Massachusetts we encourage the participation of the parents, the family physician, and various community resources, in particular the center's own clinical facilities, in the actual job of problem solving and treatment of children attending public schools. This gives us the opportunity to clarify for the community and ourselves the proper mental-health functions of medical services on the one hand and educational institutions on the other.

The three phases of mental-health programing in Massachusetts—promotion, consultation, and early case finding and clinical treatment—are completely dependent upon each other for their proper development.

Thus our mental-health program begins to look like a true public-health enterprise, interested in the emotional growth and development of *all* the children in the school system. We begin to make some progress away from the idea that mental-health programs offer nothing but psychiatric treatment for sick children.

Research Needed

It is too early to speak of evaluation. We do not yet have techniques for measuring the "mental health" of a school or a community, necessary for purposes of comparison 10 or 15 years hence. Hence we are dependent upon impressionistic statements from school authorities, such as "the mental-health consultant has been very helpful to us this year." We are in great need of basic research using public-health and social-science techniques. The work is also handicapped by a tremendous shortage of trained personnel for mental-health work and almost no facilities in the country for training in community mental-health practice.

There is always a lag between knowledge and the development of specific programs to apply the knowledge. Today, however, a sound body of fact and theory is available from the fields of child psychiatry, social psychology, anthropology, pediatrics, and education which can form the basis for sound school mental-health programs. It only awaits the passage of time, as the understanding of the nature of such programs becomes more general and trained professional workers become more plentiful, before such programs will begin to make their contributions towards the development of mature, healthy members of our American society.

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Conflicts in modern cultural values have played a major role in producing . . .

THE EXILED DELINQUENT

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SEGREGATION OF GROUPS of people from the rest of society plays a major role in the production of delinquency and criminal behavior, as well as in its perpetuation, despite the best efforts of persons and organizations concerned with the rehabilitative processes. Desegregation is *the* treatment indicated for large numbers of convicted offenders and adjudicated delinquents.

There is one common denominator among all persons in conflict with the law—that society has found them to have used socially unacceptable means to achieve ends that may or may not be socially acceptable. Since our society is so productive of both crime and delinquency we may well ponder why so many youngsters and adults are prone to violate social restrictions.

Robert Merton provides some food for thought in his volume, "Social Theory and Social Structure,"[1] in which he points out that, while the goals of our society are highly articulated, the means of reaching those goals are not at all well defined. This contrasts with the patterns of the more primitive cultures described by anthropologists.[2]

In primitive cultures not only is man's goal quite clear but ritualistic custom and strong taboo mark the path for achieving it. Childhood and adulthood are often clearly delimited by initiation rites. Socially sanctioned training is given for vocational function which is group oriented rather than individually oriented. The path toward important phases of life's activities—birth, courtship, marriage, childbearing—is clearly marked as is the process for life's minutiae. Nonindustrial older cultures have means and ends which are equally well articulated.

Such cultures also produce deviants from the norm but their deviation is more likely to be along neurotic rather than delinquent lines. Observers in Iraq, for example, recently reported that, while childhood delinquency is practically unknown there, the incidence of childhood hysterical disorders is high. In other words, when deviant behavior is clearly suppressed and forbidden, family and culture conspire to develop a strong super-ego in the individual, who drives his hostile impulses inward rather than taking them out on the community.

Goals and Means

Popular magazines, television, and other mass media create and portray our cultural goals. They are clearly related to being young, beautiful, sweet-smelling, rich, powerful, loved, and admired. Not so clearly defined are the means of achievement. Ostensibly our way is guided by the Judaic-Christian teaching—"Do unto others as you would have them do unto you"—but this is often left for the Sabbath only. In real life the stress is on aggressive, individualistic competition. The prize is to the one who arrives. If he has taken a short cut to get there, that isn't too important. Social nonconformity grows where there is a marked disparity between verbally sanctioned means and those that are really acceptable.

The task of growing up in America is further complicated by the fact that we have quite properly developed values consistent with the democratic process. We hold for individuality, nonconformity, vertical progression through class lines, and equality of opportunity. Here again, however, a marked difference often exists between articulated values and real life. One need not look far to perceive areas wherein individuality and nonconformity are penalized, vertical progress limited, and equality of opportunity denied.

Growing up in the democratic society *must* be

Based on a paper presented at the 1955 Forum of the National Conference of Social Work.

difficult since the premium is on finding one's own identity rather than on having identity defined by society. The end result is a more expanding culture than that which is produced by standardization. The difficulties are enhanced, however, when there is a pronounced difference between preaching and practice. How are family and community to transmit culturally accepted means and ends to the young when there is such uncertainty in defining just what is acceptable?

This culture, like all others, depends upon the family and the community, as manifest in social institutions, to induce conformity to social demands. Because of its paradoxes the family structure and the social institutions of the community must be particularly strong. When they are not, numbers of persons are shut off or segregated from the collective source of group strength and identification and are prone to strike out at the community from which they are isolated. From the ranks of these come many of our delinquents and criminals.

A particularly dramatic effect of basic separation from the source of forces which make for social adjustment can be discerned among infants who are deprived of maternal care during the first years of life. Freud has described the infant as "all id" and the function of loving as laying the foundation for cultural adaptation. Bowlby has amassed evidence which suggests that the absence of a loving teacher in the early years is a primary factor in inducing psychopathic behavior.[3] In other words, deprivation of the satisfaction of instinctual urges during early years so weakens the civilizing process that the individual becomes impulse driven and unable to withstand frustration. As a result he grabs to get what he wants without reference to socially sanctioned means, and so sets himself apart from the social process. This is a type of segregation induced by family failure.

Slum areas, such as this, tend to produce frustration resulting in a subculture with vague or conflicting values. Adjustment may require a child to develop ways unacceptable to society.

Community Failure

Segregation may also be induced by community failure. This is dramatically illustrated by the disproportionate number of criminals and delinquents bred in the city slums. Clifford Shaw's pioneer studies[4] clearly illustrated the manner in which slum environment produces delinquency regardless of the particular ethnic group involved. Slum dwellers are isolated from the larger community by their inability to achieve the socially accepted goals of power and prestige and by their feeling of failure. Often their failure to achieve has been related to their status as members of an unaccepted minority group and consequent aggravation of feelings of rejection. Such multiple frustrations give rise to aggression toward those beneath and above them on the social totem pole.

The child growing up in the slums quickly perceives that the fight to survive is a literal fight. As Allison Davis' studies[5] have indicated, he adapts to the slum community but in a manner unacceptable to society as a whole.

Delinquents and criminals developed by this type of community-induced segregation tend to form what Frank Tannenbaum[6] has defined as a criminal subculture—a group within society which strives toward accepted materialistic goals through unorthodox means. Such groups have their own loyalties and code of behavior. Doing time behind bars comes to be accepted by them as something which happens in the normal course of events.

Bernard Lander's recent study on delinquency in Baltimore[7] indicates that the failure of the slum community to induce social conformity stems from the presence of intergroup conflict which militates against the development of a spirit of togetherness. Using the techniques of factor analysis Dr. Lander shows that the common concomitants of delinquency, such as poor housing and poverty, are not accompanied by crime and delinquency when a collective strength amongst the persons burdened by such problems engenders positive group feelings.

Such findings make it possible to see how suddenly developed middle-class communities, without com-

Restriction of his freedom through forced detention tends to aggravate the young offender's concept of himself as an "outsider" unless the institution is staffed and equipped to rehabilitate through therapy and other creative institutional programs.

munity services or tradition, may be limited in their capacity to induce social conformity. Each family comes to such developments separately, removed from contact with kith and kin, lacking any sense of "togetherness" with their neighbors.

Some individuals experience both family and community "shutout." This is most common in the slums where the same factors that disorganize community life prey upon the tissue of family life. The type of delinquent produced by this kind of segregation is exemplified in the works of Fritz Redl[8]—the slum child who is reared in a succession of foster homes, broken family units, or unbroken but extremely pathological families. Unlike the delinquent whose behavior is induced by community shutout only and manifested in defective superego function, this doubly deprived delinquent usually has severe ego impairment.

On the other hand, many persons are exposed to community segregation but induced to social conformity by enclosure in family units. The slumbred nondelinquents in the recent Glueck[9] study were deterred from delinquency by the superior quality of their family culture. This imparted a sense of "togetherness" which made them impervious to the influence of the slum community.

Thus, the inducement to antisocial behavior in persons is largely determined by the degree to which their family life or their community life fails to impart a sense of togetherness. There are, of course, also instances of crime and delinquency produced as a symptomatic expression of a neurosis. Social work's error in the past has been to consider these relatively few instances as the whole and to assume that all delinquents could be treated without reference to their isolation from the aspirations and ethics of the larger society.

The major role social disorganization plays in the production of crime and delinquency is clearly revealed by the fact that the present increase in delinquency is accompanied by an equivalent increase in adult criminality. Unless we are to view this relationship as fortuitous, we must look for causative factors affecting both adults and juveniles and so must raise our sights beyond parents, schools, or comic books. This forces us to the unpleasant conclusion that social disorganization is on the increase; that we are failing to bring increasing numbers of both children and adults into the large scheme of social values. Unable to find a source of strength in a collective sense of purpose and dedication many individuals cannot attach themselves to the social whole and, like meteors which crash through emptiness, finally end in collision.

Formalized Separateness

Whatever differences exist amongst those who break the law, a "secondary homogeneity" is induced once these individuals are brought before the bar of justice.[10] The neurotic and the end products of family and social segregation, all are marked as offenders against society. The very separateness that leads to their antisocial behavior is formalized. No matter what the intent of treatment, the offender views the experience in simple terms of punishment for wrongdoing. Free-floating guilt arising from long-forgotten deeds or buried wishes becomes attached to the immediate circumstances. Without therapeutic intervention, this guilt induces anxiety which is dispelled by acts of hostility. Society's action, therefore, in bringing the offender to justice, more often than not fixes his concept of himself as segregated and adds psychological fuel to the fire.

The consequence of a finding of guilt—and to the youngster concerned an adjudication of delinquency is the psychological equivalent of a finding of guilt—is invariably a restriction of freedom. In a culture which places high value on individual freedom this action accentuates the apartness of the convicted—the greater the restriction, the greater the segregation. Probation involves some restriction but institutional commitment is the final and dramatic act of segregation, placing the offender in a community of offenders set apart from "good citizens." The social structure built up by the institutionalized is often continued after their freedom is restored. Thus society's mechanisms for protection actually become mechanisms for the production of criminal and delinquent subcultures.

Courts and Institutions

Much of this would not come to pass if the institutions for dispensing justice were capable of dealing with the problems brought to their doors as well as with the problems they themselves produced. In the first place, court function should be limited to situations in which the unique contribution of the law is required. Communities which maintain the juvenile court as the door to child-welfare services and make adjudication the price of service unnecessarily impose the stamp of segregation on many children and their families. Moreover, police officers more interested in running up records of arrest than in exercising the discretion legitimately theirs would sometimes serve the community better by an act of omission. In times such as these, when interest in delinquency borders on the hysterical, it is well to remember that some aggressive behavior is normal and that the best course of action in dealing with it is sometimes none.

When individuals do come before juvenile or criminal court, they should have fair hearings with due process of law for adults and appropriate safeguards for the civil rights of children and their parents. Too often frank corruption of justice or short cuts taken for administrative reasons reinforce the troubled person's concept of the larger society as hostile and unfair. We social workers can see this easily as far as adults are concerned, but we often miss it in regard to juvenile and young offenders. Our vision becomes obscured by the trappings of treatment meaningful to us but not to the offender.

For the adjudicated offender the properly trained probation officer has a rare opportunity to be of service. Since the probation officer is vested with the formal legal authority of the court and his services are usually offered to an unwilling client, there is often created a microcosm of the latter's struggle against social authority. By transforming formal authority into what Elliot Studt[11] has termed "psychological authority," the probation officer can help the client to mobilize his strengths to make full use of the testing period allowed by the court and to see his rebellion against authority and the self-destructive ends it serves. The probation officer's personal acceptance of authority as a positive quality and his treatment of the offender helps those who have been shut out by the community to revise their own concept of authority. The client's dependency on the probation officer's authority recapitulates a parent-child relationship and so offers opportunities for offenders who have experienced family shutout to perceive interrelationships and act upon that perception.

In a similar fashion an institution which is based on belief in an individual's capacity to grow, can prepare those it segregates for reunion with the larger society. By maintaining a permissive atmosphere it can crack the shell of the offender who expects retaliatory punishment and is ready to give as good as he gets. When his expectations are not fulfilled, vulnerability to change is created. If the institution has a rich and varied program it can then provide opportunities for the offender to develop his potentials and to test the new reality coming into focus.

Correctional facilities staffed and equipped to rehabilitate persons rather than to create new problems are all too rare. This is despite the fact that it is far less expensive to rehabilitate than to provide for longtime penal care. Similarly the qualified probation officer can serve selected individuals in their own homes at one-third the cost of the institution—and more effectively. Nevertheless, there are States with practically no probation service. In every State some persons are committed to correctional institutions merely because there is no probation officer to supervise them in their own communities.

Society's Rejection

Why in a society with both Judaic-Christian and materialistic values is it so difficult to find support for social provisions which are both godly and economical? Plainly, because some fundamental resistance is encountered. The real nature of this resistance is revealed when we compare the enormous public appetite for stories of crime and delinquency with the persistent public desire to punish the criminal and delinquent.

None of us is totally immune to the social forces which produce the criminal and the delinquent. The same forces that lead to overt criminality make it difficult for many of us who are not behind bars to handle our aggressive, destructive impulses. Our dim recognition of these impulses propels us toward the delinquent or the criminal with consuming curiosity, but at the same time repels so that we must hate and punish the offender. We cannot forgive him because we cannot forgive ourselves. We cannot let him "get away with it" lest our own hostile impulses get away with us. The criminal and the delinquent serve a tragic social function as scapegoats for the fancied sins of "good citizens." Thus, the segregation within the family, the segregation within the community, and segregation by the correctional processes are compounded and overlaid by the segregation of public wrath.

Social workers are not immune to the factors that produce the public's reaction of rejection, but their influence has a more subtle manifestation in our professional life. We, too, have exiled the delinquent and the criminal by our overall lack of interest in the field of corrections; by maintaining services chiefly for groups that have no room for the aggressive, the hostile, and the obstreperous; and by closing access to casework skill to the heavily burdened, downtrodden, and disenchanted poor and opening it to the middle-class neurotic whose suffering is similar to our own and whose aggression, like our own, is displayed in symbols rather than in open hostility. There is still a long way to go in spreading our recently awakened interest in the hard-to-reach.

When one talks either to social workers or the general public about crime and delinquency the interest soon shifts from the offender to prevention. It is much easier to consider health and welfare services for a deprived 7-year-old than to come to grips with the hostility of a 19-year-old thug. However, prevention cannot be achieved by the small potatoes of tiny additions to this or that therapeutic service, but only by that social and spiritual reformation that will bring our real values into accord with our verbalized values. Without that major reformation we can have neither prevention nor treatment since a community that is oriented to dog-eat-dog competition does not care enough to support the requisite programs, services, and facilities in the necessary quantity or the necessary quality.

When we encourage or allow the focus of community concern to shift from the hard fact of the delinquent and the criminal to the illusion of prevention, we provide the community with an easy out. The basic problem is nowhere more sharply focused than in the community's handling of the offender. If the cry that has come down through the centuries, "Father, forgive them for they know not what they do," has significance in our age, why must we punish and brutalize the offender? If we are our brother's keeper, why do we exile him?

If we cannot deal constructively with open hostility directed toward us in our own community, how are we to deal with our own hidden hostilities or the hostility directed toward us as a nation? To the extent that we can help the community in facing up to the problem of the delinquent, we shall be successful in creating a community in which basic religious and democratic values are both theory and practice. This is the community that cares and through caring meets its collective needs and is cared for and thus establishes a bridge between the individual and his society.

The task is enormous and the danger of failure great. The issue is not just *punishment vs. treatment* for offenders; but *love vs. hate* in our society. If hate triumphs and we can only meet hostility with hostility, then our day is lost indeed. If, however, we can face hostility and act, not out of our own hostility, but out of a perception of the needs of those who aggress against us, we shall not only bring the delinquent out of exile, but we shall move forward toward a world in which men can live in peace and harmony with one another.

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Ways of handling interagency communication depend on . . .

WHO WANTS TO KNOW?

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INTERAGENCY COMMUNICATION consumes great blocks of time in any health or welfare agency. The time is often given grudgingly and the whole process regarded as a nuisance. Yet this task has possibilities of being of benefit to the agencies themselves and to the people they serve. The process can be stimulating and invigorating instead of a chore or a bore. Making it so depends on tailor-fitting the reply to meet the needs of the recipient. How this is done depends to a considerable extent on *who wants to know*.

When information is exchanged effectively between agencies, a number of benefits result: *primary* benefits or "products," and *secondary* benefits, or "byproducts."

Primary Benefits

The *primary benefits* are the direct results: the immediate benefit to the individual on whose behalf the information has been sought; the benefit to those who help the patient; the joint thinking in behalf of the child.

The immediate benefit to the child is, of course, the major concern, but its achievement often comes through *helping those who help the patient* in a sort of relay fashion. At any given time one agency or one worker may stand at the point where the program meets the patient, while the rest of us take our place as in a bucket brigade, busily passing along materials to help the one who is closest to the problem.

One of the ways we do this is through the *selective* reporting of information. This kind of reporting gives information functional value. It reports data chosen on the basis of its usefulness to the inquirer and its applicability to the situation for which it is requested. It involves *who* wants to know, plus *what* they want to know, and *when*, *where*, *how*, and *why* they are planning to use it.

Who wants to know? is the key question. Its answer opens the door to other vital questions, such as: What is the actual situation for which this information is sought? or what sort of information might be most helpful?

By considering *who wants to know* we can establish and appreciate a frame of reference for our report. The information might be intended for a schoolteacher, a plastic surgeon, a group worker in a summer camp, or someone else whose special skills touch the child's life. In each instance the type of inquirer and the nature of his needs would influence the selection of material.

There would be certain common denominators of information which all inquirers would want and need—for instance, items of general information, identifying data, and other facts which might convey an overall picture of the child and his environment. In addition, each person seeking information would need special types of data, desirable, or even indispensable to carrying out his particular kind of service.

As for giving the patient the *benefits of joint thinking*: in the thoughtful exchange of information, more is involved than simple reporting. The informational exchange is not a mechanical transaction like the operation of a public scale which presents a man with a card containing a statement of his weight.

It is, rather, a collaboration involving those who give and those who receive the report.

There are three critical points at which this collaboration is actually accomplished: when the request is *made*; when the request is *received*; and when the request is *filled.*

When the request is made the inquirer can help by indicating how he intends to use the information. Take the following request:

"We understand that Herbert is known to you because of a slipped epiphysis of the right hip. Will you please give us a report of your findings in this case?" This is going to produce a different reply than if it were worded thusly:

"We need some medical information to guide us in planning for Herbert Jones. At present we are attempting to arrange a boarding-home placement for him. One possible placement involves a three-block walk to school; the other involves about twice that much walking to get there. We would appreciate some help in knowing just what Herbert is able to do and whether any special precautions are required. Are there any restrictions on the amount of walking he should do? Should he avoid all sports or are there certain ones in which he might safely participate? In one of the proposed homes the other children participate in the housekeeping activities. Would it be all right for Herbert to do this, and if so, are there any precautions which he should observe?"

When the request is received, the recipient himself has an opportunity to inquire: "What sort of information would be most helpful to you people?" Such a question often comes as a refreshing surprise.

In filling the request the person scanning the available data can select the cream of the material—"cream" in the sense of its special helpfulness to the person who will be using it for the child's benefit. A report so assembled might say something like the following:

"We are sending you the enclosed information about Rudi Oroco. We believe that Rudi's teacher would find it helpful to know that as a result of the numerous ear infections he has had in the past year, he has a moderate loss of hearing in the speech range and should sit well toward the front of the room. The school nurse will want to know that his ear condition is at present under the care of the otologist, Dr. Jefferson, a summary of whose findings and recommendations is enclosed. You will note that Rudi's hearing is to be retested in January."

When reporting involves such collaboration between givers and receivers, the child gets the benefit of what sometimes amounts to a miniature case conference. Under such circumstances, reporting is not a static rendering of a statement of the status quo, but a dynamic way of moving the child's care forward.

Secondary Benefits

The *secondary benefits*, or byproducts, include:

1. ***Indirect benefits to other patients or clients.*** It is axiomatic that every well-cared-for patient or client tends to enhance an agency's quality of care. The achievement sets new standards. Moreover, the activities that go into providing that high quality care establish new insights and set up new operating methods. Each individual working on the case acquires a bit of new competence, and at the same time, the agency itself gets a new vigor in the form of improved administrative methods.

2. ***Improved administrative methods*** bring about more effective use of existing resources—funds, facilities and personnel—for functional reporting results in functional development of policy and procedure. Good reporting actually stimulates the clarification of policy. Many agencies find that almost every report they issue produces at some point the comment, "Oh! Is *that* your policy?" Somewhat like Moliere's character who was astonished to learn that all of his life he "had been speaking prose," the reporting agency realizes for the first time, that it actually does have a policy on the subject; that the conduct of the specific case is not just an isolated situation, but actually an expression and application of agency policy which perhaps never previously had been articulated or even formulated.

An agency can be on the alert for these spontaneous expressions of policy, and the procedural methods improvised to execute them. Recognized as "newborn" policy and procedure, and not lightly dismissed as isolated, unrelated "decisions," they can be recorded, adopted, and put into official use. Policies and procedures produced in such a fashion have vigor, life, and relevance.

Functional reporting is also apt to bring about increased interdisciplinary communication within the agency. As soon as an agency attempts to render tailor-made, custom-built reports, designed to be of maximum helpfulness in terms of *who wants to know* the recipient of an inquiry tends to clear with other staff members on certain aspects of the information to be given out. The resultant collaboration not only produces a better balanced, more valuable report, but has a strengthening, unifying action on the agency's staff. "Teamwork" becomes more than an empty word and is now a real collaboration and interaction.

3. *Improvement of resources.* Improvement of resources proceeds through three main channels: staff development; interagency development; and community development. While improved administrative methods bring about a better use of resources, staff development and community development improve and even create the resources themselves.

The improved communication within an agency, and the actual give and take with the outside world, offer new dimensions to the individual staff members. They provide a tangible way for agencies and the various professional disciplines to join forces for productive use of one another's talents. The process engenders respect—for the child as an individual, and for the unique ability and contributions of each agency and individual serving him. In such collaboration, each professional person brings his own special talents to bear on the child's problem and simultaneously learns more and more about what others have to offer him. As a result the participants gradually become better in their own lines. Learning each other's viewpoints, they become richer and better endowed in the valid individuality of their own special professions and agencies.

The desire for interagency cooperation is easy to express, but the actual cooperation is difficult to achieve and requires every implementation possible. Sound methods for the exchange of information offer workable tools which quietly and almost automatically get some degree of mutual working relationships under way between agencies. The value of this can scarcely be overestimated.

Two methods for achieving interagency and community development include program interpretation and health education. Functional reporting can strengthen both.

Good reporting interprets policy as well as stimulating its formulation. It also interprets programs and agencies. Every report that an agency issues interprets that agency to the community. While the inept report may give little or no information about a patient, it speaks eloquently about the weaknesses of the agency sending it. A helpful, well-thought-out, clearly stated report presents between its lines a vivid picture of the agency that prepared it.

An example of functional reporting strengthening health education might occur in a maternal and child health agency's collaboration with a welfare agency in the care of an unmarried mother threatened with toxemia. Given a clear interpretation of the meaning of the girl's condition, the welfare agency would be blessed with new insights as to the importance of prenatal care, the particular significance of prenatal diet, and the urgent nature of toxemia and eclampsia. A health department rendering adequate reporting in such a case might achieve more meaningful and lasting health education on prenatal care by this means than by formal education sessions for the welfare staff.

The central role of an official agency is community leadership. An enlightened leadership harnesses the finite means which the community offers to attack the infinite problems which the community presents. The weapons—funds, facilities, and personnel—are seldom confined to any single agency, but are scattered about not only through other agencies, but through the whole community. In its leadership role the agency must develop methods of communication which effectively utilize and strengthen those community potentials.

A Case Report

Let's see how, instead of a perfunctory response with an assemblage of miscellaneous data about a patient, a case report can be a thoughtful presentation of selected features, relevant to the situation for which the information is sought:

An agency serving crippled children received a request from a school for information regarding a child with cleft lip and palate. The query came by letter from the school principal's office, and asked for information about Dinah Rinehart, a 9-year-old girl who had just come to the school from a different section of the city. It stated that the school personnel understood that Dinah had been under the care of the crippled children's agency for surgical repair of cleft lip and palate, and would appreciate a "summary of the findings."

The agency took the request literally. Some fatigued staff member laboriously thumbed through a bulky record of its 9 years' acquaintance with Dinah and chronologically enumerated a hodgepodge of medical and social highlights of the little girl's life. These included such matters as the date of the lip repair, the attempts that had been made at palate closure, the dates and place of hospitalization, and reference to a siege of postoperative pneumonia and to repeated ear infections. The report also recorded that Dinah's mother had died when the child was 7 years old and that she had been living with her maternal grandparents ever since. It mentioned that

Dinah was now understood to be repeating the third grade.

When the school personnel received this information, they were just about where they had started. After all, they had Dinah herself with them, and so were not surprised to hear that she had a "repaired lip and an unsuccessfully closed palate." To be sure, they had not known that she had had complications of pneumonia and ear infections along with her other difficulties. But even with the agency's letter in hand, they could not tell whether these past illnesses were of historic interest only or even at this late date might be exerting an adverse effect on her school adjustment. They knew too that her mother had died of some lingering illness 2 years earlier. As for Dinah's school status, they already possessed data on that.

Nevertheless, the school was not displeased with the agency's reply. It was regarded as being as satisfactory as such things usually are. It fulfilled the purpose of "clearing with other agencies." It confirmed impressions which they already had, and it "completed Dinah's file." But it did not help the people who were trying to help Dinah.

Functional Reporting

Fortunately for Dinah, two concerned persons united their professional efforts in her behalf—the school nurse and the nursing consultant from the crippled children's service. One afternoon they got together in the office of the crippled children's agency, and looked through Dinah's old record, with the purpose of making functional summaries in terms of the needs of the people who were trying to help her.

They made one summary for Dinah's teacher, one for the surgeon who was contemplating possible further surgery, one for the school nurse herself, and one for the public-health nurse.

All of the summaries carried the same basic data—chronological highlights of Dinah's nine harassed years—but in addition each was individualized with specific terms of practical meaning to the recipient. For example, all four reports contained speech and hearing information including the findings of repeated audiometric examinations. In the report for the teacher these were briefly summarized but fully interpreted in terms of classroom meaning, such as "seating in the front of the room." The teacher was also given full data on past psychological examinations and some other available material throwing light on personality factors.

The report for the surgeon contained fuller details of early medical experience, including much that was nonsurgical but which would need to be taken into consideration if subsequent surgery were to be of maximum usefulness. For instance, there was a succinct summary of a wealth of pediatric material indicating that Dinah's nutritional status and general condition might need to be improved before she was subjected to any more elective surgery. There was also some important material about her past bleeding and clotting times and hemoglobin levels which had previously caused trouble.

The public-health nurse, through her report, was provided with all of the foregoing data and queried regarding the status of Dinah's grandfather, said to be careless of a positive sputum.

Later on the agency received two more requests for reports about Dinah. In both instances the same basic data were included in the reply, but interpretations were individualized and additional items selected to make the reports genuinely useful to the inquirers—the leader of a summer camp where Dinah was being considered for a "scholarship," and an orthodontist who was making a treatment plan.

The concept of "functional data," as exemplified in these reports on Dinah, was vividly expressed recently by the chief social worker of a child-placing agency working out foster-home placements for children with rheumatic fever. Said she: "We don't want data on sedimentation rates. We want data on tennis games." She explained that sedimentation rates meant little to her agency but that information as to whether a boy might be allowed to play tennis, and if so, what precautions he should take, was highly pertinent to its planning.

A tally of informational exchanges between agencies will usually fall into a pattern revealing that the majority of requests received by any agency tend to come from a few sources. When these are known it would be administratively practical for a representative of the agency and of these sources to get together to work out details concerning the general types of information which they all would find helpful. The general guide thus developed could be used for assembling basic information concerning most of their clients or patients when inquiries are received. Interpretations and additional information in the reports could then be individualized by the workers.

Through such functional reporting the best interests not only of the child involved and of the person trying to help him but also of the requesting and reporting agencies and the community at large would be served.

A Cleveland hospital demonstrates the emotional value of . . .

GROUP WORK WITH HOSPITALIZED CHILDREN

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IN THE PAST 4 YEARS a program of groupwork in the Babies and Children's Hospital in Cleveland has grown from an experimental stage to one characterized by confidence and acceptance. It came about as part of an effort to broaden the focus of the pediatric division and has become an integral part of the division's program.

Anna Freud visited Cleveland in 1950, stressing the effects of sickness and hospitalization upon children. Afterwards, the hospital's child psychiatry outpatient department planned to expand its services to the division of pediatrics. As the hospital achieved a more creative pediatric child-psychiatry program it paid increasing attention to the emotional problems of the hospitalized children. These problems included: the effect of separation from parents and home; feelings about loss of independence, freedom, and privacy; reactions to injections, anesthesia, and other procedures.

This change of focus resulted in a number of outward changes. Daily visiting hours were instituted by the hospital administration. The social-service department assigned caseworkers to each of the wards and in 1951 instituted the groupwork program.

The first groupworker was assigned to the medical ward. She had to learn a great many things about her task. True, the way the groupworker functions within the hospital setting has a basic similarity to his functioning in any agency where groupwork is more traditionally practiced. The goal is still "through some satisfying group experiences to help individuals to develop their social relationships and to help them to deal with the problems presented by their environment and to use the resources of this environment in a constructive way."[1] However, in many aspects a hospital setting is different from others. Usually a group in a traditional groupwork agency is formed because of the members' common desire to participate in a special activity. In a hospital setting this is not the case.

Joining the Group

Joining the group is one of the few things that hospitalized children can choose to do or not to do. However, the experience they share in the hospital is a strong potential for drawing them together. Their fears, anger, and anxieties can be more powerful than a common interest in cooking or woodwork or even closeness in age. The age range of a hospital group is broad, sometimes ranging from 4 to 14 years.

In her efforts to encourage relationships by consciously grouping children or introducing appropriate kinds of program activities, the groupworker makes use of the common bond of illness and of the parental role in which the children cast her. She sometimes places beds and wheelchairs in strategic positions to enhance the children's awareness of one another. Although a child may be in the next bed to another youngster, they may not even begin to relate to one another unless purposeful means are used.

This was true of 10-year-old Pat, who when the group worker first saw him had been on the children's surgical ward for about a week. He had been trans-

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"Props," like the glove-type puppets these children are wearing, can help the hospitalized child escape his environment in the world of creative imagination. Helping immobilized children to play together as normally as possible is one of the social group worker's chief functions on the ward.

ferred from the adult floor where he had been in a respirator following an attack of polio and where he had been the "darling of the ward." He had been moved to the children's ward because his doctor felt that he needed the company of youngsters his own age. However, he still had no contact with children as his parents were constantly hovering over him. He was never interested in doing anything suggested by the groupworker in her bedside rounds before the start of the evening meeting, but preferred to continue playing with his father. He ignored the meeting even when it was held at his end of the ward.

Pat's father, however, became interested in what was going on. Several times he asked the groupworker what this playing and talking "was all about." The group worker told him how helpful this play could be, especially for a child who was afraid and lonely in the hospital. The father said that maybe Pat "wasn't a good customer for the group," but added that perhaps the boy had been with adults too much and needed the company of other children. The groupworker agreed, saying that Pat would be welcome in the group when he wished to come.

The father showed considerable understanding. He began to go out to the waiting room more often for a smoke, leaving Pat with nothing to do but to watch the youngsters at their play. Eventually, with encouragement and support from the groupworker, he began to make occasional comments during the discussions or games. One evening when the worker asked him whether the group could meet by his bedside, Pat looked uncertainly at his father, then back at the worker, and nodded his head. However, there was almost no interaction between Pat and any other child. Several times in the course of the meeting he asked for his father, who would not only come and be with him but also take part in some of the group activities.

As time passed Pat began to relate to the groupworker. When activities such as guessing games were underway he would always direct his questions or answers to the worker, who would serve as his "communicator" with the other children. The rhythm band, an activity which did not require much interaction with the others, became an important way for him to take part in their activities without calling attention to himself.

Because of his paralysis Pat had very little use of his arms, but he learned to fashion some things out of clay and to paint somewhat awkwardly. He always appeared ashamed of what he had done and would crumple up his work and throw it away. The groupworker encouraged him to take as many pieces of paper as he needed to "practice." This individual activity "in," although not "with" the group, was an important step.

Eventually, Pat began his own attempt to be a part of the group, by suggesting games to play, usually those where objects were passed from one child to another—an indication of his need for physical contact with the other children. His father stayed out in the waiting room for longer and longer periods without protest from Pat. The other children began to include *him* in the group. They asked him about his illness when they discussed theirs, and picked him often in the games in which children choose others for a turn. Gradually Pat became a person of fairly high status among them.

Status in a hospital group frequently is determined by the child's length of stay, his age, or his illness. Pat attained his because he was an authority on the various ward procedures. The worker would call on him frequently to "explain" things, and he became a source of great reassurance to the other children. For example, when a medical technician came on the ward to take blood from a child Pat sensed the anxiety and discomfort of the other children. He reassured them by explaining that the process was not as bad as it looked, involving only a tiny prick and that he had gone through the procedure many times. Eventually he became the group's undisputed leader.

More and more, as his relationship to the worker and the children strengthened, Pat was able to express both anger and affection toward them, although he still reacted passively to the extremely painful and frightening treatments administered by nurses, doctors, and other therapists.

Role Playing

One evening, Pat and several other youngsters clamored for "a real hospital play." This meant that all the props had to be real. The groupworker got a stethoscope and several surgical masks and other instruments from the nursing personnel. The group decided, with Pat very active in the decision making, that the play should be about a patient's admission to the hospital.

That evening the group was composed of Pat, 3 other boys his age, 3 younger boys between the ages of 5 and 7, and 5 girls ranging in age from 5 to 11. All of them wanted to play the part of a doctor who had been especially sensitive to their needs. Pat and the oldest of the other boys won out. When the groupworker explained that other roles were also important, the girls accepted the parts of nurses. The role of patient, wanted by no one, was assigned to the younger children, who had the least status in the group. The role of the mother was discarded when Pat, as doctor, said that he would bring the patient to the hospital himself.

The play involved many injections and much knee tapping and taking of blood pressures. It finally wound up with the decision that the patient would ultimately die. At this point the group's interest seemed to wane, and the children moved on to another activity without showing much anxiety.

However, the next evening the groupworker had barely entered the ward before the cry was on for another play. "But," said Pat, "this time it is going to be murder."

The group decided that the play might still center around the hospital and that the main figures should still be the doctors, but, at Pat's suggestion the doctors were to be the murder victims. The group's unanimity was unmistakable. Now nobody wanted to be a doctor, and the two youngest children were made to take the role. Pat and his close friend of the day before became the murderers and the girls became the police and judges.

The play took many forms—a chase, a capture, an escape, a trial, and another escape. When time came for the meeting to close, the worker tried to wind things up by asking how the play would end. With great vehemence, Pat, who earlier had decided the doctors had to die because "they hurt my pal," declared that the doctors had to remain dead; that the murderers would be caught and punished.

In the warm, nonthreatening atmosphere of a group, children often play out, or talk out, their anxieties and fears about the whole experience of being in the hospital, as Pat and his friends did in the two plays they created. The sick child's world is the hospital and the people in it are the important figures in his life. They are doctors and nurses, who may be friendly figures but who still can administer frightening and painful procedures, and other patients, who come and go. Sometimes a child may regard anyone who comes in from the outside, even his own parents, with hostility. This was evident in Pat's play when the mother role was discarded.

Sick children have to cope with the physical manifestations of what ails them as well as with the experience of pain. Their confusion may engender some fantastic ideas which may or may not come to consciousness. When they are hospitalized they often have the feeling that their parents have deserted them and left them in the hands of persons who want to hurt them. One of the purposes of the group is to help them bring these notions out into the open where they can be dealt with.

Play-acting can be therapeutic as well as fun. The "bad man" in the foreground, about to shoot the ether can and so put the doctors and nurses to sleep, gives the patient-actor, and the other children as well, a chance to discharge their feelings against the treatment received in the hospital.

As they chose or were assigned to their individual roles the children in Pat's group were investing themselves with a kind of therapeutic power. For instance, to be the doctor was to be the person who controls the lives and the comings and goings of sick children. To be able to identify with the doctor brought an opportunity to be as powerful and punishing and hurting and helping as he seemed to be. Through this role Pat played out some of his own feelings and ideas about doctors. He continued this the next evening by having the doctors killed.

In such play the groupworker brings in reality through assisting some children in their various roles, discussing what the play can really mean, and in many subtle ways helping the children to discharge their anxieties safely. At the same time, the children know and are reminded when it seems necessary that this is *not* "real"—but make-believe. They are aware that they are pretending to be powerful, to hurt, and to cure. There is discussion of the various roles played. At no time should youngsters play roles that would be damaging to them.

Getting Underway

To the groupworker accustomed to other settings, the hospital environment can be a strange, new, and amazing place. She is faced for the first time with large wardrooms, with children of all ages and all kinds and degrees of illnesses. The hubbub of various procedures, personnel, and parents can be a confusing experience.

At the Babies and Children's Hospital the pediatric casework supervisor had explained the purposes of the new program carefully to the nursing staff so that a start toward good relationships between nurses and groupworkers was already underway before the groupworker had even arrived on the ward.

Equally important in the evolution of the groupwork program was the help, support, and advice that the groupworker received from an advisory committee formed under the leadership of the director of social service. Several disciplines, including psychiatry, pediatrics, nursing, social casework, social groupwork, and education, were represented.

This committee met weekly for 2 years and followed the program closely in order to help to launch and reenforce it. The groupworker kept detailed process records of all her meetings with the children as the basis of her reports to the committee.

The committee helped to make decisions. It advised, for example, that the groupworker should meet with the children for four consecutive evenings each week in the period between dinner and bedtime, when staff activities had lessened and parents had left.

The committee asked many questions which helped the groupworker see her role more clearly, to weigh the value of various program media such as dramatics and games, and to consider other aspects of the group, such as the effect one child might have on another.

The committee also made suggestions about working with and communicating with the caseworkers, the nurses, and the doctors. It discussed the significance of the various mechanisms of defense as expressed by the youngsters in their play and talk and what response from the groupworker would be appropriate to each. They discussed the meaning of children's denial of their illnesses, identifying with the aggressive figure in the hospital environment, repressing frightening feelings about some of the hospital procedures, and general behavior.

After the groupwork program seemed to be running smoothly on the medical floor a social groupwork student from the School of Applied Social Sciences was assigned to it for her fieldwork experience. The worker moved to the children's surgical floor. There she observed a difference in reactions.

On the medical ward the fears and anxieties seemed much more on the surface, making it easier for the child to talk about them. The children there had to submit to treatment procedures but they could not see from where their illnesses stemmed.

On the surgical ward the group worker saw youngsters manifest great anxiety before surgery. Often the child could talk fairly freely at that time but afterwards evidenced complete amnesia about how he had felt before the operation. The surgery "had been fine," or there was "nothing to it." The advisory committee stressed the importance of not allowing the youngsters to repress these feelings. It advised the groupworker to make an effort to get at some of the same fears that had been present before.

Sometimes the worker was able to do this by helping a youngster who had been through surgery to explain to others in the group what it was like. She pointed out that these children might have had many fantastic ideas about what possibly could have happened. From the fairly safe vantage point of having gone through a frightening experience, it then became possible for the child to talk. This helped him to relive and to master in a much less frightening and less traumatic way some of his original fears and worries. Often too, reliving the experience in a play situation and under conditions that the children themselves made was an effective therapeutic tool and a help in warding off greater anxieties.

In addition to helping the groupworker the advisory committee sponsored several teaching seminars for pediatricians, surgeons, social workers, and other interested personnel. Among other subjects they focused on: preparing children for anesthesia and surgery; the meaning of "shots" and other procedures to children and methods of understanding and handling their reactions; the effects on the children of radical surgery or death on the ward.

Staff Cooperation

The richest services to children have been in those instances where the collaboration between groupwork and casework has been immediate and intense. The groupworker is a member of the social service department. However, she works with all of the youngsters on the ward whether they are referred to social service or not, and whether or not they have special problems. Therefore she can spot youngsters whose problems are not immediately obvious, and can refer them to the caseworker.

Jimmy, aged 7, was an extremely quiet child. The personnel regarded him as "the model patient." He had been run over accidentally by his father, who was backing his car out of the garage, and was suffering from fractures of the back and jaw. The groupworker noticed his extreme depression, and his inability to take any part in the group activities. She also noticed the absence of his parents during visiting hours. She brought these observations to the attention of the caseworker.

When the caseworker talked to Jimmy she discovered that he was confused and terrified and did not know why he was there. She called his parents and discovered that they too were frightened and felt too guilty to come in to see Jimmy because "he might feel better if he did not see us." She worked with the parents until they were visiting daily, and with Jimmy until he was less frightened and depressed. Both workers conferred about Jimmy for a few minutes each day. Gradually he became more friendly with other children and began to participate in the group. He also became able to talk about his accident and his experience in the hospital in a realistic manner.

The groupworker's contacts with nurses and doctors go beyond clearance to see whether a child's condition permits participation in a group. Some staff members, when not under pressure, have taken part in the group activities themselves, thus giving the children an opportunity to see them in roles other than the accustomed ones. To be able to give play "shots" to "real" doctors and nurses has been a source of great gratification to some youngsters, and has helped them to express their feeling about the medical profession more freely. To get a glimpse of some of the real feelings youngsters have about them and about hospitalization in general has helped some of the doctors and nurses to greater understanding.

Although the groupworker has many contacts with the hospital personnel, the greatest avenue of exchange is the ward conference. This grew gradually from an informal getting together of caseworker, groupworker, and doctor to a regular weekly meeting of the caseworkers assigned to the ward, the groupworker, the internes, the chief resident, the consulting psychiatrist, the psychologist assigned to the pediatric department, the recreational therapist, the nurses, and students of the various disciplines.

The discussion centers on children who are referred or should be referred to social service. The goal is to formulate plans for better care for them while in the hospital and at the time of discharge, but a valuable byproduct is the constant learning and teaching.

The Values

The chief values groupwork can offer hospitalized children are reassurance and the opportunity to discharge tension in an atmosphere that is permissive and nonthreatening. We have observed the reassurances that these children can give each other are far beyond those that can be given by an adult, whose help, no matter how well-meaning, often appears as a new threat. As good as a relationship can be between children and adults, significant and understanding communication from one child to another carries greater weight.

Perhaps the child who benefits most from the groupworker and the group is the one who is helped to make the transition from a passive, compliant patient to a much more active, even aggressive one.

The program also provides reassurance to parents through the knowledge that their child is with other youngsters and with a warm and sympathetic adult.

From the hospital's point of view it is an important part of the team effort to help hospitalized children to have a less frightening hospitalization.

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[1] Coyle, Grace L., Fisher, Raymond: Helping hospitalized children through social groupwork. The Child, 16:114-117, 126, April 1952.

Self-study in relation to changing times has led to . . .

NEW EMPHASES AT THE CHILD WELFARE LEAGUE

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RECENTLY the Child Welfare League of America, alert to the need for keeping its services abreast of changes in children's needs, made a detailed study of its functions and program. This study, financed by the Bernhard Foundation and directed by Katharine F. Lenroot, formerly chief of the Children's Bureau, has been published in a booklet entitled "Today and Tomorrow." Some of the thinking which brought about its findings and the current activities and plans for the future to which they have already led will be outlined here.

Services to children and, more important, the needs of children have changed radically since the League was founded in 1920. If the League is to continue to be useful it must gear its program to the changing needs of its member agencies and the children for whom they are responsible.

At its founding the general mandate to the League was improvement of all forms of service to children. Over the years it has worked in this direction mainly through its function as an accrediting agency and by providing information on sound child-welfare practice. It has developed a variety of activities: staff consultation with member agencies; publication of professional materials; periodic regional conferences on child welfare; the conducting of child-centered community or agency surveys; coordinating an interagency service for children needing such care.

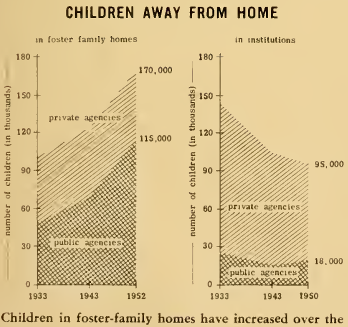
Through these efforts, and those of many other persons and organizations, tremendous strides have been made in the child-care field since 1920. In that year the evils of baby farming were being exposed. Large congregate orphanages were only beginning to be replaced by cottage-type institutions. In many States children still worked long hours in factories. Homeless children were sometimes shipped on special trains from large cities into smaller towns where they were stood up in churches and chosen for free foster homes by more or less well-meaning people. Adoption of homeless children was only beginning to become "respectable." Social casework was just beginning to have an impact in the child-welfare field.

Conditions Today.

The changes over the years have reflected a gradual awakening to children's longtime needs as well as a response to new needs. Among children's institutions 25 percent have refocused their operations from giving custodial care primarily to serving as specialized resources for children who cannot live in an ordinary community setting. Skillfully planned foster-home placement has replaced the practice of putting children into free homes. New resources such as day-care centers, foster-family day care, and homemaker service are beginning to prevent many long-term, full-time placements. Adoption has changed from a dubious, seldom-used method of providing care for children, to an extremely popular one in which the present problem is a too short supply of the kind of infants in demand. Improved public-assistance programs, family-welfare programs, child-guidance clinics, and counseling services have had immeasurable effect in reducing the number of children who must be cared for away from their own homes.

With reduction in the number of orphans and others with long-term dependency needs we have been able to give more attention to the treatment of children with personality disturbances. This move has been greatly accelerated by developments in psychiatry and by the interdisciplinary exchange between social work, psychology, and education. Today narrow lines of specialization are breaking down. The various professions and branches of professions concerned with delinquents, school social work, child guidance, and foster care are recognizing their common interests. All of these developments have been achievements of a public more sensitive to the needs of disadvantaged children.

Despite these gains, the 250 member agencies of the League reporting on local conditions for the study revealed that many, many children needing service are still unserved. Thousands of older children, handicapped children, and children from minority groups are deprived of permanent homes, due to the lack of adoption resources for them. Thousands of emotionally disturbed children who could be helped, were facilities available, are growing up to become social misfits, criminals, or patients in State mental hospitals. Sadly inadequate correctional resources reflect in great part the philosophy of half a century ago. In many parts of the country child-welfare caseloads, particularly in public agencies, are so high that children get but casual care. In some areas practically no services are open to Negro children. Hundreds of children's institutions without casework service take children under care not knowing whether or not they really need care away from home and are unable to maintain valid contacts with the children's families. "Black" and "gray" markets in adoption have sprung up and are flourishing. Thousands of substandard commercial day-care homes and commercial foster homes present a serious hazard to children.


CHILDREN AWAY FROM HOME

Children in foster-family homes have increased over the years as the institutional population has declined.

Against this background we have planned the League's future program. Among its implications are the following:

1. *A different type of field service, expanded in scope, is necessary.*

Back in 1920 when the League was started there were few well-trained social workers in the child-welfare field. The task of the League's staff then consisted in large part in going into a community and "telling" people what a good child-welfare program was and helping them get one started. In this way the League was in part responsible for the development of many State departments of public welfare, the framing of State child-welfare laws, and the reorganization of many private agencies.

Today, however, all the States and a great many localities contain well-qualified social workers in the child-welfare field. They know what good programs and good standards are, and they are striving to achieve them. The League's function has shifted to that of a "communicator" and a "management consultant." This includes the responsibility of keeping abreast of nationwide trends that may not be discernible in any one town or any one State and of new methods developed by one community that might be helpful to others. Through field consultation the League helps member agencies by impartial reviews of their programs.

However, the League is conscious of many areas in which the needs of children are not being provided for even on what we know to be essential minimums. For example, 25 years ago the League began efforts aimed toward ending the institutional care of infants and very young children. Since then over 200 institutions have recognized the harm such care can do to the child's emotional development and have abandoned it, usually developing foster-home care for the very young instead. Nevertheless many, many institutions remain that either do not know of or do not heed the extensive research which has revealed the psychological damage which can occur through early institutional care.[1]

There are still hundreds of child-caring agencies outside the stream of professional social work, agencies that do not have caseworkers or diagnostic resources to determine whether the children and families they serve actually need or can benefit from what they can offer. The League must continue to persuade the boards of such agencies of the necessity for professional services and to help the agencies obtain them. Therefore, the study recommended that the field-service program to both member and nonmember agencies be accelerated.

2. *Child-welfare practice must reflect modern scientific knowledge.*

The study strongly recommended that the League do its utmost to promote interdisciplinary cooperation in the child-welfare field and to encourage the fuller utilization of the findings of other fields. Anthropology, genetics, sociology, psychiatry, pediatrics, psychology, law, and religion all have rich contributions to be made to the care of children. Often new findings in those fields are not known to children's agencies, and, conversely, often the problems and knowledge of children's agencies are not known to the representatives of these disciplines.

The League is a standard-setting and accrediting agency. Standards of practice must reflect the best scientific knowledge available from all sources. A major revision of standards in the child-welfare field has not been made on a national basis during the past 15 years. The study recommended such a revision as a top priority.

This recommendation is already being acted on through the generosity of the Ittleson Foundation of New York City. A substantial grant from the Foundation will enable the League, in the next 3 years, to reassess and redraft standards in all areas of child welfare, including foster-home care, institutional care, adoption, homemaker service, service to unmarried mothers, and work with children in their own homes. In this task the League will work with the Children's Bureau of the U. S. Department of Health, Education, and Welfare, the Family Service Association of America, other national agencies, its local affiliates, councils of social agencies, and State departments of public welfare. It will draw upon all available resources in related fields, with the object of producing a dynamic document which will reflect the best current knowledge.

The League plans to keep standards up-to-date in the future by reviewing them at frequent intervals and changing them where subsequent knowledge proves a standard outmoded.

Shortly the League will publish the results of its second national adoption conference. This conference was preceded by a study financed by the Rosenthal and Heinz Foundations, of adoption practices in over 200 adoption agencies in the United States. The findings were correlated and distributed to a group of persons representing various social and biological sciences. These scientists met with 300 adoption workers in Chicago earlier this year and closely examined the practices of adoption agencies in an attempt to determine which could be scientifically supported, which were unscientific, and which needed further research to test their validity.

One result of this conference was the realization that perhaps no field in child welfare is changing more rapidly than adoption. Practices that were considered the very best but 5 years ago are now outmoded. Agencies are experimenting with new and dramatic ways of finding homes for children heretofore thought unplaceable. They are discarding some former "safeguards" as unnecessary; they are improving diagnostic methods and are willingly subjecting their every practice to the scrutiny of others. The League's work in keeping participants in the adoption field closely in touch with each other will continue and will serve as a pattern for its services to other fields of child care.

3. *The research program of the League must be greatly stepped up.*

One type of research should be directed at ascertaining trends that will affect child-welfare programs.

Since a large percentage of all children in institutions in this country today are emotionally upset it is essential that outmoded institutions adjust their programs to provide treatment resources for children who have been so damaged that they cannot live in a family setting. The League is currently conducting a detailed study, financed by $26,000 in foundation funds, to determine what is happening in some 500 children's institutions. This research has been preceded by a 2-year study of residential treatment centers, which has revealed ways in which institutions can improve their services to disturbed children.

Another facet of the League's research is in probing conditions of child care, searching out weaknesses and finding ways to improve them. One way the League is extending this part of its program is through embarking on a 3-year action-research project, a scientific study of conditions of children in foster care in the United States. Financed by the Field Foundation, this study is in part patterned after the research recently conducted by the Citizens'

Committee on Adoption in California. It will attempt to find the obstacles that have prevented agencies from making permanent plans for children and that have resulted in children remaining in foster care longer than necessary. In studying cases of individual children it will appraise the effects of laws relating to the rights of parents, and the absence or presence of professional personnel. It will attempt to determine how many children in foster care could be made available for adoption, were resources available, and what resources are needed.

It is hoped that by studying States that have various patterns of social-service structure or laws, some clues will be found as to the best methods for insuring children permanent homes. In each State or area studied a citizens' committee will be enlisted to work with the research staff, to serve in an advisory capacity, and as an action group to improve conditions of foster care.

The League will also add a staff member to study existing State adoption indexes, such as the one in Ohio. The purpose will be to formulate a uniform system of indexes and encourage all States to establish this type of clearinghouse for bringing agencies with children for whom homes cannot be found in touch with agencies having prospective adoptive parents but no children. When a sufficient number of States have created such indexes, the League will set up a national adoption index. It is hoped that many hard-to-place children will find homes through such a device.

Through its work with the United Community Defense Services the League has found that the tremendous increase of defense industry, atomic-energy installations, and the movement of Army camps have resulted in many children being cared for under harmful conditions. The absence of day-care facilities for working mothers is a major contributing factor. Having studied this situation, the League has worked with defense forces and atomic-energy plants in an attempt to develop better day-care programs and other facilities for young children.

Research can also help to improve the efficiency of social agencies. In collaboration with the Children's Bureau, U. S. Department of Health, Education, and Welfare, the League is conducting a joint study to develop better methods of cost accounting for children's institutions. Financed by grants from the New York Foundation and the New York Fund for Children, this project is attempting to develop a uniform method for determining costs of various phases of an institutional program and for various types of children. Such a method would enable institutions to compare costs and, to a degree, program efficiency.

4. The League must become far more active in community organization.

The form in which social agencies are organized in a community greatly affects their efficiency and economy. For instance, multiple-service children's agencies are apt to provide better service for children than a number of unconnected agencies. The League is interested therefore in finding out what other forms of organization are efficient—for example, whether all services needed by unmarried mothers should not be provided in a single agency rather than being spread among three or four, as is commonly the case.

However, a great deal of study is necessary to determine what combinations of services have proven most worth while and under what circumstances. Today there is a great deal of loose talk about the advantages of combinations of agencies, with some specialists in community organization recommending that practically all social, psychiatric, and health agencies be merged into one. No systematic study has ever been made of this problem. The Family Service Association of America and the Child Welfare League are currently seeking funds to conduct a joint study of the results of various types of mergers, particularly of family and children's agencies, to determine what conditions make for the most successful merger and what conditions are conducive to failure.

Today communities are beset with what is often a serious imbalance of resources. Some areas have good foster-care programs but very weak programs of aid to dependent children. Such an imbalance results in some fatherless children going into foster care because their mothers, for economic reasons, cannot care for them. Again, a community may have a good family agency, a child-guidance clinic, and a good foster-care program, but no protective services, with the result that some of the most desperate situations go unobserved until the child forcibly brings them to public attention by becoming seriously delinquent. Another community may have good institutions and good foster-home-care programs, but be completely lacking in homemaker or day-care programs which can serve some children far more adequately than removal from home. Much greater investment needs to be made in such programs almost everywhere if well-rounded services to children are to be developed.

5. *The general public's unawareness of child-welfare needs is perhaps the greatest obstacle to improvement.*

Before any child-welfare organization, local or national, can achieve marked improvements in program, greater effort must be spent in public education. Ours is a rich country. I believe that most people would be willing to spend tax dollars or give private contributions to aid children, if they knew why such aid is necessary. Unfortunately, large segments of our population have no idea of what we mean when we speak of the quarter-million children who must be cared for outside their own homes. Most of them think we mean orphans, though the full orphan has almost disappeared from our population. They may believe in providing decent shelter, food, and clothing for them but be completely unaware that psychological starvation is by far the greatest problem of most of these children. Fortunately, our national media of communication give evidence of growing public interest in these problems.

The League is working cooperatively with one national TV and radio network to insure accurate interpretation. It helps many popular magazines with articles on child-welfare subjects. Currently it is producing a film on foster care with one of its member agencies.

A Task for Many

In addition to these major recommendations the League's self-study contained many having to do with the organization's internal programs. Most of them are concerned with strengthening and improving various aspects of its service to member agencies: its membership studies which serve as a base for accrediting child-welfare agencies; its regional conferences which serve as educational tools for the field; its employment service for child-welfare workers; its relationships with other national organizations; and its international program.

The League is but one of many organizations in this country that can help improve conditions for children. Over 1,800 private agencies in the United States concentrate exclusively on providing children with foster care. Public agencies in most of the 3,000 counties carry on similar activities in addition to other services to children. Leadership and stimulation in raising the standards of care provided by these thousands of child-caring agencies must come from many sources—public and voluntary. Councils of social agencies, State departments of public welfare, the American Public Welfare Association, the Children's Bureau of the U. S. Department of Health, Education, and Welfare, all bear a major responsibility in this regard.

We hope that eventually the outworn tag of "dependent and neglected children" will be dropped. We also hope that the resources of social work, of psychiatry and psychology, of guidance clinics and foster-care agencies, will be recognized as services directed essentially toward the same children.

Practically all children in foster care today come from situations that breed emotional disturbance. They represent one of the most vulnerable groups of children in our population. Because of the long association of the care of "dependent and neglected children" with a pure problem of custody, few of them had the attention of the behavioral services. There is a dearth of research regarding effects of foster care on children or on determining what conditions in foster care are conducive to sound psychological growth and what are harmful.

In many areas it is still the privilege of any person, regardless of background or ability, to set up an organization to care for children. So far no one has come forward to suggest that it should be illegal for any organization to attempt to care for children unless it has adequate professional personnel for determining whether they need care outside their own homes and unless it has the use of casework staff for working with a child and his parents toward eventual restoration of the child to his own home or toward another permanent plan, such as adoption.

We can also hope that in the near future there will be universal recognition of the institution as a specialized resource. Institutionalization is not a way of life for children, but rather a means to an end—a resource to serve special needs, the needs of children who for certain reasons cannot live in a more normal community setting but who can benefit by the unique contribution of group care.

Fulfillment of hopes depends upon action. At the League it is believed that the study of its program will serve as a chart for action. "In so doing," states the report, "the League will not only contribute to the welfare of children and young people throughout the Nation, but will strengthen the foundation of our country's life by helping children to grow into citizens who are strong enough to love freedom and wise enough to cherish and use it."

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[1] Bowlby, John: Maternal care and mental health. New York: Columbia University Press, 1951.

INTERNATIONAL STUDIES ON GROWTH AND DEVELOPMENT

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STUDIES OF GROWTH and development in the normal child have always been connected with North America by European workers. The reason is clear: the amount of work in this field carried out in the past and at present in the United States is very large. Comparatively, the reverse is true of European countries, and of most others. Because of the paucity of modern information available on this subject outside North America, a study of the growth and development of normal children was started in London in 1949.[1]

At this point it is necessary to review briefly the situation in this field up to this time in the United Kingdom. For the purposes of this article the only types of studies under discussion are "longitudinal"; that is to say, studies which follow the *same* children over a period of growth. Very few standards of growth are available in Europe other than those based on "cross-sectional" data—or data available on large groups of children at various ages. Even these data are in the main sadly out of date.

In Scotland, a longitudinal study was carried out on boys and girls in 1927 by Professor Alexander Low, and some standards of anthropometric measurements have recently been published.[2] The Social Medicine Unit in Oxford started a study in 1943, but most unhappily this was terminated in 1952 through lack of funds. Data from this study have been published, and excellent publications continue to appear.[3, 4]

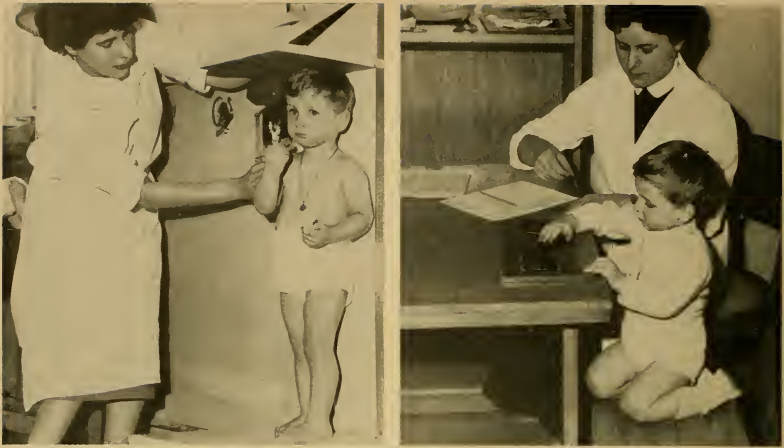
In 1948 a study jointly sponsored by the British Ministry of Health and the Sherrington School of Physiology, St. Thomas' Hospital, London, was begun which actively continues. The subjects are children living in one of the centers of the National Children's Homes, an organization caring for orphaned or deprived children. While the children may enter the centers at almost any age, on the whole this study concentrates on the older child. The investigations are most comprehensive. A large team of specialists attend the regular monthly sessions when data are collected. However, no psychological investigation into the mental development of the children is carried out. Moreover, the sample is somewhat selective. This study and those in Scotland and Oxford seem to have been the only reasonably recent longitudinal growth studies in Europe preceding the establishment of the London study in 1949.

The London study was jointly set up by the Institutes of Child Health and Education in the University of London. It was planned from the start as a fully comprehensive longitudinal investigation on "normal" children from birth to maturity. The oldest children in the sample are at present approaching 4 years of age.

In this project the growth of the children is studied physically and psychologically while full recognition is taken of antenatal, postnatal, socioenvironmental, nutritional, and genetic influences. The basic team of investigators consists of two psychologists, a pediatrician, two research assistants, and a secretary.

Continental Studies

In 1952 a happy series of events occurred. As a participant of this study I mentioned in a short paper read at the annual meeting of the British Paediatric Association at Windemere that there was a dearth of comparative information available upon growth from different countries. I added that, ideally, national growth studies could compare information which, apart from their individual value, would yield valuable data upon racial and other influences affecting the development of the children.



A French child contributes information to the Paris growth study. *Left,* his physical growth is measured. *Right,* he participates in a psychological test. Studies under way in five other countries are coordinated by the Centre International de l'Enfance.

These remarks prompted Professor Robert Debré, the French pediatrician, and president of the Council of the Centre International de l'Enfance in Paris, to get together with Professor Alan Moncrieff, Nuffield Professor of Child Health in the University of London, and myself. The three of us planned an entirely imaginary growth study to be set up in Paris and to be sponsored by the Centre International de l'Enfance. This, we dreamed, would run on lines exactly parallel to its London twin.

Could we make this imaginary plan a reality? Many difficulties had to be overcome.

The first step was taken in 1953 when I was invited to work in Paris with the Centre International de l'Enfance for that year, and was granted leave from the Institute of Child Health in London. My duties were to collect a team of French investigators and to spend the year setting up the new French study under the auspices of the Centre. My job was not to teach French scientists how to run such an investigation—a task they were perfectly capable of performing already—but to make sure the two studies were parallel. Moreover, I could see that the Paris study was not hampered by the mistakes we had made in starting our London study.

Although the Centre International de l'Enfance is administratively run by the French and is located in Paris, its activities are directed by a Council which is international in the true sense of the word. Partly financed by UNICEF, its ever-broadening activities include: running postgraduate teaching courses on a large and worldwide scale; providing an excellent bibliographical service; and conducting extensive research. It was therefore natural for the Centre to encourage a project involving cooperation between two groups of workers in different countries.

During that year of 1953 the work of getting the Paris study underway continued and various feelers were put out with the aim of extending the project further. When a Swiss member of the Centre's Council expressed keen interest I paid a visit to Zurich where a study was being planned. The pediatrician who was to run the Swiss study then spent a month with us in Paris learning the techniques and methods common to the Paris and London studies. Then the Swedish and Belgian members of the Council expressed interest in setting up cooperating studies in Stockholm and Brussels.

The snowball had started rolling and was getting a bit heavy. It was clearly time to review the whole situation and organize ourselves. Many meetings occurred during the next 6 months as these studies got underway. In October 1954 the first international "working-party committee" of these studies, and others proposed, met in Paris under the auspices of the Centre.

International Cooperation

The committee faced a major question: if various countries were going to run studies on growth of normal children would it be possible to agree upon a common "baseline" of investigations? It was considered extremely important for each national study to be free to follow whatever particular lines of research it wished. No one ever suggested that any central organization should direct what should or should not be investigated. Nevertheless, if the different countries *were* going to carry on such studies, then a common simple baseline to be followed by all would be invaluable for comparing data. It would be a tremendous pity if this great opportunity were lost.

By the time of this meeting, the London, Paris, and Zurich studies were already underway and the Stockholm and Brussels studies were ready to start. Representatives from all these countries' working teams were present at the meeting along with various experts invited to criticize and help. The miracle happened: we fairly quickly agreed on a clear-cut basis for investigations under the main headings: antenatal, postnatal, health, socioeconomic, and anthropometric factors. This was not accomplished overnight nor without some diplomatic measures which might have surprised experts in the United Nations; but it *was* accomplished and with great good humor.

The most difficult task was for a subcommittee composed of a group of international psychologists to reach agreement about the factors to be included in regard to the all-important psychological and emotional development of the children in the studies. There were many points of argument: to "test" or not to "test"; to "interview" or not to "interview." Nevertheless, the subcommittee did arrive at a "baseline" for material on mental and emotional development and this is widely comprehensive.

The common baselines of investigations, as we call it, is published in restricted form for the use of the workers in the various studies.[5] It is but the first, we hope, of several guides.

The committee stressed a vital point: a growth study must grow and change. Methods alter. The children develop. Therefore the Centre agreed to sponsor an annual meeting of representatives from the various teams so that results can be compared, methods criticized, and improvements planned continuously.

At the time of writing the London, Paris, and Zurich studies are progressing, while pilot studies have been started in Brussels and Stockholm. Two other studies are planning to use suitable parts of the "baseline"—one in Dakar directed by Dr. Jean Sénéchal, and the other in Kampala directed by Dr. R. F. A. Dean. These two African studies are highly specialized and deal with malnourished children. Together with the studies in Zurich, Stockholm, and Paris, they are financially aided by the Centre.

A Growing Snowball

There is also a possibility that an American team will attach itself to this snowball of international cooperation. A year ago, at the instigation of Dr. Alex Steigman, professor of child health in the University of Louisville, I spent a month in the States, where we discussed plans for a project in Kentucky and where I had a chance to discuss the "baseline" with experts from the Children's Bureau of the U. S. Department of Health, Education, and Welfare. The Kentucky study would investigate the normal growth of Negro and white children.

Clearly the snowball grows and there is no evidence that it has come to rest. At least we hope it will produce reliable international data—surely a great reward for pushing it off down the hill.

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[1] Moore, T., Hindley, C. B., Falkner, F.: Brit. Med. J., 2: 1132, 1954.

[2] Low, A.: Growth of children. University of Aberdeen, 1952.

[3] Stewart, A. M., Russell, W. T.: Med. Offr. 88: 5–8, 1952.

[4] Acheson, Roy M.: J. Anat. 88: 498, 1954.

[5] Falkner, F. (editor): A baseline for research into the growth of children. Published in English and French. Centre International de l'Enfance, Paris. 1955.

An essay-review . . .

CULTURE AND PUBLIC HEALTH

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MUCH HEADWAY has been made within the past 20 years in developing techniques of getting across ideas in public health. During the early part of this period the emphasis was upon the use of different media and when this was done for people of the same culture the results were usually quite successful. We recognized that people of different educational and environmental backgrounds would react better to materials geared to these backgrounds.

We even developed material in other languages if necessary but these were usually translations of materials developed for English-speaking people, not materials specifically designed for people of other cultures. If, in addition, we used illustrations depicting the race for which the material was developed, carrying out the recommended procedures, we felt the adaptation was complete.

The fact that these materials were frequently quite popular and successful gave us an even greater feeling of confidence.

One of the earliest agencies to recognize that this was not sufficient was the Bureau of Indian Affairs, U. S. Department of the Interior, which used ethnologists, cultural anthropologists, and sociologists to interpret to their staff the cultural differences of the tribes with which they were working and how teachings would have to be modified to make them acceptable to the people.

When the United States became interested in helping Latin-American countries and when we took part in the technical-aid programs the importance of understanding the cultural backgrounds of the peoples receiving service was brought home to us even more forcefully; and the sociologist, cultural anthropologist, and community worker became part of the health team. Many reports of their experiences and conclusions are available and are well worth studying.

Now recently the University of Colorado School of Medicine has realized that it has not been as successful in obtaining acceptance of its recommendations regarding health among its Spanish-speaking patients and so has added a sociologist to its staff, Lyle Saunders, associate professor of preventive medicine and public health.

He has been successful in interpreting to the staff and students the cultural differences that must be taken into account in understanding the frequent failures to obtain acceptance of Anglo medicine.

A Help to Understanding

Much of this material he has gathered together in a volume "Cultural Difference and Medical Care" recently published by the Russell Sage Foundation.[1]

He has developed a very readable book which should not only be of assistance to all physicians, nurses, welfare workers, teachers, and others working with cultures other than their own in accomplishing their objectives, but should make their task a much more pleasant one because it will help them develop an understanding, liking, and sympathy for the people with whom they are working.

The book will be particularly valuable for those working with Spanish-speaking people in the field of medical care.

The author gives the book a very human quality by describing in the first chapter the occupants of a house made into apartments in the Spanish-speaking section of a large Southwestern city. It is occupied by Spanish-Americans, Mexican-Americans, and people recently arrived from Mexico. Their health problems, the differences in their attitudes, and the situations that arise from these are related.

In the later chapters, discussing the cultural background, differences in culture and the problems these cause, and the folk medicine of the different groups of Spanish-speaking people, the actions of these families are interpreted and we realize how very logical, in the light of this background, some of their seemingly illogical actions may be for them.

The fifth chapter is devoted to programs that have been set up to provide medical service for Spanish-speaking people and why some of them have failed, and how the gap between the two cultures may be bridged.

The last chapter is devoted to the importance of a background of the social sciences and humanities as well as the present medical- and nursing-school curricula in permitting each worker in health to "make more effective use of all their knowledge and abilities and thus contribute to the attainment of their individual and collective goals."

The notes to the chapters should not be overlooked—they are unusually meaty.

For people working with Spanish-speaking people this book is a must. Even if they are themselves Spanish-speaking, and have worked with Spanish-speaking people for years, they will enjoy seeing all of their impressions and bits of knowledge knit together in an understandable whole. For those who have less experience, a careful reading and digestion of this book could add much to their efficiency and acceptance.

Public-health administrators should find this book an excellent stimulation to reevaluating their programs in the light of their effectiveness when applied to a different cultural group.

When the acceptance of the fact that the cultural background and attitudes of the people we wish to reach is just as important a factor as the health concepts we wish to impart in the final goal of improving the health of a people, our entire approach to the problem takes on a broader focus. We become very much more concerned with our acceptance by these people as individuals and as members of a health organization. Will they accept a statement regarding health just because we advance it and say that well-known health authorities (who are unknown to them) state that this is the best procedure? Or must this information be related to something already known and acceptable to them?

There are several generalizations we can safely make regarding our approach to all cultures. The learning situation should be as pleasant, relaxed, simple and free of tension-producing content as possible. We should start with health content that is easily understood, is probably readily acceptable because it is in harmony with attitudes and beliefs now held, and which produces easily discernible improvement in a short time. No health practice should be changed, however markedly it may differ from accepted Anglo health practices, unless it is definitely injurious to health.

Beliefs and Attitudes

Public-health workers should be thoroughly familiar with the cultural background, beliefs, and attitudes of the group with which they are working. This includes relationships within the family and community. How often do we expect a woman to make an immediate decision regarding something such as hospitalization of herself or her child when her culture demands that she consult her husband or her father or brother or even the official council of her village? How often, in order to improve nutrition, do we recommend the basic seven foods in terms of Anglo foods when these are too expensive, unacceptable because of taboos, or undesirable because of their lack of keeping qualities under the conditions that exist, when a few minor acceptable changes may be all that is necessary to produce an optimum diet?

Do we have a proper appreciation of health practices of other cultures which have developed through years of experience and which may be much better suited to their particular situation than our practices based on a highly urban civilization?

A very thorough examination of our present public-health programs for other cultures, stimulated by these and similar questions with regard to applicability of our present health concepts and approaches to other cultures, will not only help to achieve a much more rapid acceptance of these concepts most necessary to survival but will make us clearer thinkers, better teachers, and persons much more understanding of the people of this world and of why they act as they do.

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[1] Saunders, Lyle: Cultural difference and medical care. New York: Russell Sage Foundation, 1954. 317 pp. $4.50.

BOOK NOTES

PREMATURE INFANTS; a manual for physicians. Ethel C. Dunham, M. D. Second edition, completely revised and reset. Paul B. Hoeber, Medical Book Department of Harper & Bros., New York. 1955. 459 pp. $8.

First published in 1948, under the same title, as Publication No. 325 of the Children's Bureau, this book is planned as a source of information with regard to prematurity and a guide for the general care of the premature infant.

Part I deals with general considerations—definitions of and criteria for prematurity; incidence, causes, and prevention of premature birth; and the growth and development of premature infants. Part II discusses the physiologic handicaps of premature infants, the general problems of their care, and the congenital and acquired conditions that tend to affect them adversely. Part III outlines some of the public-health aspects of prematurity, including death rates and causes of death, and cites examples of organized programs for the care of premature infants and for the prevention of premature birth.

EDUCATION OF MENTALLY HANDICAPPED CHILDREN. J. E. Wallace Wallin. (Education for Living Series, edited by H. H. Remmers.) Harper & Bros., New York. 1955. 485 pp. $4.50.

Besides giving detailed consideration to the training and education of mentally handicapped children, this book briefly discusses their socioeconomic problems.

Much of the contents is concerned with the organization, administration, and objectives of special classes for these children.

CULTURE AND MENTAL DISORDERS; a comparative study of the Hutterites and other populations. Joseph W. Eaton in collaboration with Robert J. Weil. The Free Press, Glencoe, Ill. 1955. 254 pp. $4.

The Hutterites, a communal religious group whose colonies are located in Canada and northwestern United States, were selected for study of their mental health, according to the authors of this book, because of their reputation for peace of mind. But, the authors say, "Our findings do not confirm the hypothesis that a simple and relatively uncomplicated way of life provides virtual immunity from mental disorders."

As for the formative years of these people, the book reports: "The growing Hutterite child is molded consciously and consistently by parents, teachers, and the impact of all community institutions. The goal of this fairly rigid and deterministic socialization process is the making of an adult who will live in conformity with the expectations of the Hutterite way of life. . . . Permissiveness in child rearing is not a Hutterite virtue; it is regarded as a vice."

OUR BACKWARD CHILDREN. Karl F. Heiser. Foreword by Grover F. Powers, M. D., W. W. Norton & Co., New York. 1955. 240 pp. $3.75.

Addressed to parents, psychologists, pediatricians, psychiatrists, neurologists, social workers, educators, and institution administrators, this book offers concrete advice concerning mentally retarded children.

The author maintains that such children's deficiencies are symptoms of underlying pathological conditions. He looks forward to prevention of these conditions and points to what he considers the paramount need, well-planned research.

He particularly urges differentiation between the child who is mentally defective and the one whose low IQ is due to emotional disturbance.

MIDWEST AND ITS CHILDREN; the psychological ecology of an American town. Roger G. Barker and Herbert G. Wright. Row, Peterson & Co., Evanston, Ill. 1955. 532 pp. $7.50.

"Midwest," as used in this report on children's "psychological living conditions and behavior," is the pseudonym selected by the authors for a typical small town in which they and their staff systematically observed and recorded children's behavior, not in psychological laboratories, but in the children's natural habitats. For comparison they included also a few physically handicapped children living in neighboring towns and in a school for the crippled.

The authors express the hope that in the future "psychological situations will be mapped as the physical areas of the world . . . when changes in psychological living conditions and behavior will be as carefully plotted and scanned as changes in birth rates."

SCHOOLS IN TRANSITION; community experiences in desegregation. Edited by Robin M. Williams, Jr., and Margaret W. Ryan. University of North Carolina Press, Chapel Hill. 1954. 272 pp. $3.

Some of the recent experiences of 24 communities in States bordering the South as they moved from racially segregated to integrated public schools are described in this book. The editors have divided the communities studied into two main classes, those in States whose laws required integrated schools and those in States whose laws on this subject were permissive rather than mandatory.

In communities that had a tradition of activity in intergroup relations investigators found that the transition seemed to take place with relative ease. They found also that public-school desegregation or integration only loosely correlated with the attitudes of the population: in some places school desegregation was successful in a completely segregated environment.

Where desegregation has been tried, the editors say, the typical outcome has been its eventual acceptance. The ease of transition varies greatly from community to community. Some resist the change more than others, but the direction of change is clearly toward acceptance of educational integration.

BEHAVIOR AND MISBEHAVIOR; a teacher's guide to action. James L. Hymes, Jr. Prentice-Hall, New York. 1955. 140 pp. $3.

The author divides children into two groups, the stable and the troubled, and tells the teacher that her skill in teaching discipline depends on her ability to distinguish between them. He suggests methods of helping both groups, and says: "No one way is always good in general, nothing always bad * * * Only one rule is constant: You must determine the cause, and your action must be consistent with the cause."

PROJECTS AND PROGRESS

The United Nations and Juvenile Delinquency

The First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, which met at Geneva, Switzerland, August 22–September 3, 1955, called for a United Nations study to assess the practical results of various measures aimed at preventing juvenile delinquency. The resolution suggested that nongovernmental agencies with special knowledge in the delinquency field be asked to help in the necessary fact-finding.

Why this type of study needs to be added to the extensive research program on delinquency already being carried on by the United Nations came out clearly in the section of the Congress devoted to the prevention of juvenile delinquency. This section included about half of the 565 official and unofficial delegates representing 66 nations at the Congress.

Members of the section explained conditions in their countries related to delinquency and described measures intended to help boys and girls in danger of becoming delinquent. These measures fell into four categories in relation to: (1) the community; (2) the family and the school; (3) the social services, including health services; and (4) other agencies, such as religious bodies, the police, and leisure-time organizations. In telling about them the delegates repeatedly pointed to the need for scientifically developed, objective research that would show which measures are succeeding and which are not.

Nearly all the reporting delegates spoke of rising delinquency in their countries. A number attributed this trend to increasing industrialization. Delegates from Israel, Iraq, Pakistan, India, and Syria reported that in their countries families are crowding into cities in the hope of making a living somewhat better than a bare subsistence level and that the sudden change from rural life often leads to family disorganization and hence to delinquency.

The delegates from Syria and Pakistan also attributed some delinquency to conditions among large numbers of refugees in their countries from elsewhere.

United States delegates reported on research aimed at finding ways of identifying potential delinquents at an early age.

Countries that reported favorable trends in juvenile delinquency were the United Kingdom, which in 1954 found juvenile delinquency reduced 18 percent below its incidence in the preceding year; France, which experienced more than a 50 percent decrease between 1946 and 1954; and Greece, which in 1954 experienced a slight decrease from 1953.

French delegates reported that in their country social agencies concentrate on family education. They send experts into homes to teach mothers how to care for children. They also send busloads of city children to vacation colonies in the country. Police associations form "teams of friendship" with children.

In the United Kingdom local coordinating committees integrate the activities of agencies giving services to prevent delinquency, delegates said. Special welfare offices work with boys and girls committed to institutions, and with their families, to prevent recurrence of offenses.

Israel was reported as tackling delinquency prevention through health centers, through recreation centers and through "youth-to-youth" programs under which children of different economic backgrounds get together and learn about one another's problems.

Egypt has more delinquency in the part of the country becoming urbanized than in the part remaining rural, an Egyptian delegate said. He reported that many services to deal with delinquency have been established during the past year—a social-service unit for every 50,000 of the population, recreation centers for delinquents, training schools for delinquents, treatment and observation homes, and probation bureaus.

In Denmark youth clubs under the auspices of the police seem to be bringing good results, according to a Danish delegate. The Government pays 45 percent of the cost of operating these clubs, the locality 3 percent, and the remaining 52 percent comes from membership dues and gifts.

After discussing such preventive measures, the section prepared a report which the Congress adopted unanimously for submission to the United Nations Economic and Social Council.

The report puts major stress on the need for research. In addition to the evaluative studies the Congress has asked of the United Nations, it suggests investigations into the causes, diagnosis, treatment, and prevention of juvenile delinquency. Because accurate knowledge in these fields lags far behind the good intentions of those interested in increasing social action, it suggests that whenever such action is undertaken, provision be made for evaluation of results.

The report also calls attention to the indirect measures that help to prevent juvenile delinquency, such as housing and public-health programs, but it warns that projects for general social improvement, such as these, cannot do the whole job, that programs specifically for delinquency prevention are indispensable.

All public and voluntary programs for children and youth in a community should be drawn together closely, with a specialized agency such as a coordinating council or community committee to integrate the various services, the report advises, so that more children with serious difficulties can be served in the way best suited to the child's and his family's needs, while duplication of services is avoided. It also advises closer collaboration among individual workers.

The report emphasizes the importance of reaching a child through his family rather than by direct agency intervention and of fostering family ties and a sense of belonging in the child. It suggests that young persons be helped to cope with their difficulties themselves so that they will not be led to expect that somebody else will do it for them.

The report recommends encouragement of juvenile-aid police services, given by specially trained officers. It also urges advanced special training for all professional workers dealing with juvenile delinquency.

Among other measures for delinquency prevention recommended in the report are: family or children's allowances; family-life education for parents and children, and psychological help for estranged parents; vocational guidance for adolescents; efforts to improve school attendance and to prevent employment of children during school hours.

The next United Nations Congress on Crime and Delinquency will be held in 1960. —*Philip G. Green*

Adoption

More than 1 out of every 3 of the 548 children placed for adoption last year by the Children's Home Society of California were children for whom homes were not readily available. One-tenth of those placed had physical handicaps or presented serious medical problems; 2 were blind and 2 totally deaf. One-fourth were of Mexican parentage or other minority groups.

The Society, a privately supported adoption agency now in its 64th year of operation, serves all of California through offices in nine cities in various parts of the State.

On the ground that the need for adoption services requires the joint efforts of public and private agencies, the Society has long championed public adoption programs. It supported the legislation that authorized establishment of county adoption agencies in 1947 and since then has helped various counties establish services.

Child Labor

Registration of Ceylonese house servants under 14 years of age as a step toward enabling them to get some education was urged by the senior delegate from Ceylon at a joint meeting early this year of the International Federation of University Women and the Pan-Pacific Women's Association, held in Manila, Philippine Islands.

The delegate said that 38,000 children in Ceylon are working as servants on plantations, losing all touch with their homes and lacking opportunity for any schooling. The fact that these young boys and girls receive food, clothing, and shelter blinds their parents, she said, to the virtual loss of their children, and to the seriousness of their education lack. Twenty-five thousand additional children under 14 are working in other occupations, she reported, and urged that employers and parents share responsibility for observance of the school-attendance law.

The delegates from other Asiatic countries revealed a similar concern for children in employment, but some expressed the feeling that domestic employment was currently the only advancement open to children of the villages and that therefore the avenue for improvement had to be through employers. The conference exhibited special concern for efforts to reduce illiteracy, by establishing educational facilities for all children.

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A large proportion of the more than 4,300 children under 16 that were found employed on farms during school hours in the fiscal year 1954, were below normal in educational attainment, according to the U. S. Department of Labor.

Records for 4,023 of the children old enough to have completed at least one school grade showed that 48 percent had not completed grades considered normal for their age by the U. S. Office of Education. One hundred and nineteen children had never attended school at all; 12 had entered the first grade but had never completed it.

Six percent of the children employed were under 8 years of age.

Crippled Children

Four interregional meetings on services to crippled children, called by the Children's Bureau late in September and early October, brought together administrators and other professional personnel from the States and Territories to consider ways in which these services might be further developed. Before adjournment late in July Congress appropriated for the first time the full $15,000,000 authorized under the Social Security Act as the Federal share in this program, thus increasing by more than $4,000,000 the money available to the States for crippled children's services.

Held in Denver, Chicago, Washington, D. C., and New York, the conferences focused largely on ways and means of developing services for children with specific types of handicaps—epilepsy, cardiac conditions, speech and hearing disorders, congenital deformities, mental retardation—although types of services important for all crippled children, such as nutrition and dental care, and services for specific groups of children, such as migrants and Indians, also received attention.

Speakers and panels at the meetings gave the conferees technical information on recent developments in knowledge and treatment of the conditions under discussion, and told of ways in which the various States were attempting to apply this knowledge to the children needing attention, thus revealing how geographical, economic, and other differences among the States bring individual problems to each.

Some differences in viewpoint also came into discussion—for example, whether or not the term epilepsy, which is not a disease but only an admission that the cause of seizures is unknown, should continue in use. There was, however, general agreement among the experts that an effective program of seizure control must involve three important aspects: early case finding, early treatment, and careful followup. States with such programs, it was revealed, have found children subject to seizures to be much more numerous than generally suspected.

Different viewpoints also emerged on the extent to which a State program could become involved in the free dispensing of drugs even for conditions, such as rheumatic fever or convulsive seizures, in which medicines play the central role in treatment and control. Some States have found it possible to apply a liberal interpretation of the term "medically indigent" in the provision of drugs for such conditions, while others more generally require the patient's family to pay for medicines, not only on the theory that parents should accept as much of the responsibility for the child's health as possible, but also to protect the limited funds available for the program.

Two of the conferences presented sessions on amputees focused on the Michigan program which has been cooperating with the National Research Council in the development of improved prosthetic appliances for children with congenital or traumatic amputations. The speakers emphasized the importance of frequent, periodic followup of such children and careful work with parents to help them understand the potentialities of the prosthesis.

No matter what the affliction under focus, the team concept, especially as developed in a program for children with cleft lip and palate, received major emphasis in descriptions of what might be done and is being done in some States. There was also a great deal of emphasis on the preschool period as the focus of case-finding efforts—as a time when children are most amenable to treatment, but least likely to come to attention of persons outside the home.

Care of Prematures

Five institutes in the care of premature infants are being offered for 1955–56 by the New York Hospital-Cornell Medical Center in the seventh year of a training project sponsored by the State Department of Health and the Children's Bureau, U. S. Department of Health, Education, and Welfare. They are designed for physicians and nurses in charge of hospital premature nurseries and special centers and for medical and nursing directors and consultants in State and local premature programs. The first of the series of 2-week (for doctors) and 4-week (for nurses) institutes got underway in late September. Others will take place in November, February, April, and May, if advance registration warrants them. No tuition is charged and stipends are provided to cover expenses. Further information may be obtained from Institute in the Care of Premature Infants, Box 143, the New York Hospital, 525 East 68th Street, New York 21.

Migrants

More than 100 migrant families following the crops from Florida to Virginia and New York this past summer and fall were accompanied by an observer assigned by Florida's Bureau of Maternal and Child Health to identify and report on the families' health problems.

This step is part of a 3-year demonstration project on the health of migrants which is assisted by a grant from the Children's Bureau and is under the direction of a sociologist employed by the Florida Board of Health. The information gathered is to be used in planning both a State and a national program of providing continuity in health services for migrant workers and their families, as recommended at the May 1954 East Coast Migrant Conference at Washington.

During the months before leaving the home base in Palm Beach County, Fla., each family member available was given a physical examination by county health department or local physicians. Adults were given blood tests and chest X-rays, and children received immunizations. Persons with physical defects were referred to local agencies for correction before the start of the migration. Socioeconomic data were also collected from the families.

The medical record for each family was entered on a large folder, which was presented to the family before its departure. Duplicates were kept at the project's central office in Florida. The purpose of the record folder was to give information about previous services to any health workers who might provide immunizations or other medical services to the family members during the migration, so that the patients could be helped more intelligently.

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Last summer Idaho's and Oregon's departments of health cooperated with the Public Health Service, the Children's Bureau, and the Office of Vocational Rehabilitation in carrying out a health project for more than 4,000 migratory agricultural workers and their families in several counties in the Lower Snake Valley that do not have organized local services.

The migrants arrive in Idaho about May 1 each year, and remain into November, housed in labor camps. The project sent a mobile clinic from camp to camp, giving physical examinations; blood and urine tests; immunizations against smallpox, typhoid, diphtheria, tetanus, and pertussis; and other health services. The personnel arranged for treatment when necessary, seeking the help of local physicians, and for hospital delivery of pregnant women.

Since most of the migrants are Spanish-speaking, an interpreter accompanied the mobile clinic.

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Colorado's Department of Health participated in two major projects for migrants this past season with the help of Children's Bureau funds—one at Fort Lupton in Weld County in the heart of the sugar-beet country and one in peach-growing Mesa County. The Fort Lupton project this year centered around a clinic staffed by the County Medical Society, which provided both medical examination and treatment for children and adults, in addition to the immunizations and screening for communicable disease with which the project was largely concerned last year.

The Mesa County project, which centered around increased public-health nursing and improvement of local interdisciplinary relationships and communities, was run locally with the help of State and Federal funds. Medical and dental services were available on referral and every effort was made to see that the migrants used them.

Among the first visitors at the Fort Lupton clinic were 27 Spanish-American children brought in for health examinations by school bus from Wiggins in nearby Morgan County. Children of migrant farm workers in Weld, Adams, and Morgan counties who had come up from Texas for the beet season, they were the pupils of a special summer school for migrants operated by the Wiggins School District with the assistance of the Colorado State Department of Education. The children were receiving free milk at school and, when necessary, free lunches, provided through the school-lunch program.

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An experimental summer school for migrant children 5 to 12 years old was operated for a month and a half last summer in Potter County, Pa., by the Department of Education, Pennsylvania State University, in cooperation with the University's Christian Association. Funds for the project came from the National Child Labor Committee through a grant from the Philip Murray Foundation. The project was located in the town of Ulysses and was coordinated with a number of other projects for migrants in the county, including a day-care program sponsored by the Pennsylvania Department of Welfare and a health program offering immunizations and physical examinations operated by the State Department of Health.

The purpose of the school was to find how migrating life had affected the children and how supplementary educational experience might improve their lives. Since there were 11 teachers for 43 pupils, the children received a high degree of individual attention. Tests given at the beginning and end of the school session showed that, while some of the children had improved academically, the most noticeable improvement was in nonacademic skills such as social adjustment.

In addition to the classroom work the project also included visits to the children's parents in the camp, an open house for the community, and a recreation program operated jointly with the Society of Friends.

Among the public and private groups represented on the school's advisory committee were the State Departments of Labor and Industry, of Public Instruction, and of Health; the local public schools; the National Child Labor Committee; the Pennsylvania Citizens Committee on Migrant Labor; the American Friends Service Committee; and the Philadelphia Yearly Meeting of Friends.

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Maryland's State Health Department this year for the first time organized a statewide program to provide selected health services to migrant laborers and their families. In the eastern part of the State, State and county health departments, in cooperation with the Public Health Service of the U. S. Department of Health, Education, and Welfare, gave a physical inspection, including a blood test for syphilis, to each of more than 4,300 migrants, about 300 of whom were children under 12 years of age. Without waiting for the test results, the health workers offered to give all persons over 12 an injection of a penicillin preparation. Those found positive received followup examination and treatment. Children of mothers who had been treated previously for syphilis were also tested and treated.

The services were given without charge at clinics set up at farms, factories, plants, and other places where migrants were concentrated.

Persons with health problems other than syphilis were referred to State health department physicians.

In other areas of the State over 500 migrants were given a blood test for syphilis. Those found positive were examined by the county health department and treated if necessary.

Child Development

Since 1950, when the Institute for Psychoanalysis, Chicago, began its pilot project to disseminate psychoanalytic principles of child care and education to nonmedical professional workers for children, 97 such workers have participated. Fifty-one are social workers, 21 teachers, 18 psychologists, 4 nurses, and 3 ministers. Almost all have a master's degree; some have a Ph. D. and others are working toward it.

The 3-year evening program aims to arrive at and teach a common body of knowledge basic to all fields concerning children, and to help the various types of workers make this knowledge an integral part of their own disciplines. The faculty offers not only group instruction but also individual supervision of direct work with children in a wide range of agencies, institutions, and schools in the Chicago area.

The project has a twofold purpose: to contribute to the development of better methods of helping the emotionally disturbed child and through research to learn more about the processes that facilitate normal emotional development and how to prevent interference with that development.

Continued support from the Field Foundation has made the project possible; the Moorman Foundation, the Wieboldt Foundation, and the Public Health Service of the U. S. Department of Health, Education, and Welfare have also contributed.

For Amputees

The Midwestern Area Juvenile Amputee Center specializing in the care of children who have lost arms or legs is now in operation at the Mary Free Bed Children's Hospital and Orthopedic Center in Grand Rapids, Mich. Federal funds totaling $55,000, allocated by the Children's Bureau to the Michigan Crippled Children's Commission for the establishment of the center, are to be used primarily for provision of the highly skilled service necessary for diagnosis, treatment, and training in the use of prosthetic devices to child amputees from birth through 20 years of age and the extension of specialized educational opportunities to persons working with child amputees in other areas of the country.

For many years the Michigan Crippled Children Commission has carried on a program at the center for child amputees within the State of Michigan. It will now extend this service to children from the other States. The potential area to be served by this center has not yet been determined but it will be immediately available to children from Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The Michigan Crippled Children Commission will be the liaison between the hospital and the official crippled children's agency of the State where the child lives.

Mental Retardation

A program for mentally retarded children, including diagnosis, parental guidance, coordination of community resources, community education, training of professional workers, and clinical research, has been begun by Washington's State Department of Health as a part of its crippled children's services. The program, which is expected to extend throughout the State eventually, has been begun with a center established as a "primary unit," at the University of Washington School of Medicine. The unit offers complete services to diagnose and evaluate children suspected of being mentally retarded. It is developing a teaching aspect to give medical students and pediatric residents fundamental training regarding mental retardation.

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The National Association for Retarded Children, an organization of parents and friends of the mentally handicapped, reports that it now has affiliates from 47 States as compared to 9 States in 1950. Its membership includes over 100,000 individuals and families. . . . The Hamilton County (Ohio) Council for Retarded Children is urging State legislation requiring physicians to report all cases of mental deficiency to local boards of health.

Nutrition Services

Child-caring institutions and foster-family homes in more than two-thirds of the States receive service from public-health nutritionists or dietary consultants, according to a survey made by a graduate student in public-health nutrition at the University of Michigan.

Thirty-five States replied on questionnaires that their public-health workers provide this type of service, usually in cooperation with the State department of welfare.

Evaluation of menus is the most common activity—carried out in 27 States. Food service is surveyed in 21 States. Nutrition education programs are provided for various groups: for social workers (20 States), for directors of child-caring institutions (19 States), for foster mothers (15 States). Other services given include establishing nutrition standards for licensing, training public-health personnel in applying these standards, and training food-service workers.

Safety and Accidents

An accident-prevention service to school-bus fleets, now available from the National Safety Council, provides to those in charge of bus operations the safety-training materials developed by the Council's motor-transportation division. These include awards to safe drivers, newsletters, posters, brochures, and monthly letters to be mailed to drivers.

West Virginia's schools, after trying the program during a 4-year period, found that in 1952 bus accidents were fewer by 16 percent than in the year before the program started, although motor-vehicle accidents in the State as a whole had increased 12 percent. During 1952 the State operated 20 percent more school buses than in 1948; the buses transported 14 percent more pupils and traveled 18 percent more miles.

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Accidents took the lives of 17,121 children 1–19 years of age in the United States in 1952, the latest year for which figures are available. Mortality due to accidents was highest in the group 15–19 years of age—57.1 per 100,000 children in that group. Children 1–4 years of age experienced 37.2 fatal accidents per 100,000. Among children 5–14 years deaths from accidents were somewhat fewer than in the other age groups—22.4 deaths per 100,000 children. In each of the age groups accidents were the chief cause of death.

Homemaker Service

One hundred and fourteen community agencies in 29 States and Puerto Rico are providing homemakers to families who need their help in keeping the home together, according to data compiled by the Children's Bureau and the National Committee on Homemaker Service. Of these, 94 are voluntary and 20 are public agencies.

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Guides and Reports

AN INSTITUTIONAL APPROACH TO THE PARENT-CHILD RELATIONSHIP. Milton Willner. Child Welfare League of America, Inc., 345 East 46th Street, New York 17, N. Y. 1955. 11 pp. 50 cents.

Awarded first prize for 1954 by the Mary E. Boretz Award Committee, this paper shows how an agency approached the problem of using the institutional setting to facilitate casework services to the parents of troubled children. When the parent was able to carry even a fractional part of his parental role, both he and his child found more satisfaction in the parent-child relationship.

ART AND PLAY THERAPY. Emery I. Gondor. Doubleday & Co., Garden City, N. Y., 1954. 61 pp. 95 cents.

Shows how play situations and art materials provide a medium of communication between the therapist and the child which may make it easier for the child to reveal his difficulties.

PSYCHOANALYTIC PRINCIPLES IN CASEWORK WITH CHILDREN. Selma H. Fraiberg. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1955. 54 pp. 85 cents.

Three articles, reprinted from social-work periodicals, describe efforts to solve some difficult problems in children's lives through casework.

ADMINISTRATION, SUPERVISION, AND CONSULTATION; papers from the 1954 Social Welfare Forum, National Conference of Social Work. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1955. 114 pp. $1.50.

Offers divergent opinions on "three subjects which frequently are viewed in isolation from each other but which actually are closely related."

NUTRITION PRACTICES; a guide for public health administrators. American Public Health Association, Inc., 1790 Broadway, New York 19, N. Y. 1955. 72 pp. $1 a copy; 75 cents each in quantities of 25 or more.

Planned to assist administrators of public-health departments in initiating, conducting, and evaluating nutrition services, this guide stresses the responsibility of the public-health administrator to see that the total community nutrition services are adequate and effective in meeting the existing need.

CASE RECORDS FOR STUDY AND TEACHING. Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y. 1954. 144 pp. Processed. $2.85. Separate units, 40 cents each. Discount on quantity orders of the book or its units.

Eighteen case records, contributed by public and private social-work agencies, are assembled in this collection, planned for use in the classroom and in agency programs for staff development.

SIGNS OF THE HEALTH TIMES—seen at 1955 National Health Forum on forecasting America's health. National Health Council, 1790 Broadway, New York 19, N. Y. 1955. 64 pp. $1.

Takes up a number of factors in planning health programs. Among them are: economic trends and their probable effects on health efforts; atomic developments in relation to health; new miracles to expect from medical science and how social science can help us benefit from them; the role of mass-communications media in health betterment; fluoridation; chronic illness; the Hoover Commission's health recommendations.

WORKSHOP IN THE EDUCATION OF THE EXCEPTIONAL CHILD. Arizona State College at Tempe. 1955. 275 pp. Processed. $2 plus 25 cents for mailing and handling.

Reports a 5-week workshop on exceptional children, which included sections not only on the emotionally maladjusted, the gifted, those with hearing and speech difficulties, the mentally retarded, the orthopedically handicapped, and those with reading disabilities, but also on non-English-speaking children, who are numerous in Arizona.

IN THE JOURNALS

Cross-cultural research

Items, published quarterly by the Social Science Research Council, summarizes in its September 1955 issue a 3-day conference on cross-cultural research on personality development held in Kansas City, Mo., last spring. Anthropologists, psychologists, and sociologists from 13 universities took part, along with the members and staff of the Council's committee on personality development. This committee is continuing the work of the former subcommittee on child development of the committee on social behavior.

The participants repeatedly expressed the need for a general theoretical model comprehending the relationships of society, culture, and developing personality. One suggested step toward this objective, to which the conference itself was regarded as a contribution, was the planning of limited studies, whether by anthropologists, sociologists, or psychologists, with joint attention to such problems as the relation of social structure to socialization.

The conference emphasized the increasing necessity for specialists in the sciences concerned with personality development to share one another's theoretical perspectives, even with regard to research techniques.

The bomb and genetics

The July–August issue of *The Cancer Bulletin*, published by the University of Texas contains an unsigned article on the genetic effects of the atomic bomb. This finds reassuring the results obtained so far by the Atomic Bomb Casualty Commission from the survivors of Hiroshima and Nagasaki in that no significant increase in abnormalities has been found in the first generation. Cooperative study by Japanese and American scientists will need to continue for many years, however, the article says, before conclusive results are available.

Results of a 1952 study are summarized, which "although not conclusive, demonstrate that a fetus in utero may receive sufficient radiation from an atomic-bomb explosion to produce defects of the central nervous system if the mother is within approximately 1,200 meters of the explosion and is not well shielded."

When children can't sleep

Disturbances of sleep in children are the first reliable signs of emotional conflicts, maintains Melitta Sperling in the *Psychoanalytic Quarterly* for July 1955. She adds that this symptom precedes any other overt indications of such conflicts. The article includes six clinical examples of sleep disturbances due to severe neurotic or psychotic disorders. Commenting on the child's actions in one of these cases, the author suggests that this kind of disturbed behavior should not be confused with the actions of a healthy child who, in a desire to participate in the activities of adults, will invent all kinds of devices to postpone going to bed.

Child health in 3 countries

Advances in various fields concerned with child health in Great Britain, Canada, and the United States are described as part of a report on 1954 developments in public health in those countries in the July 1955 issue of *Good Health*, a quarterly issued by South Australia's Department of Public Health. Improvements in maternal and child health, child health, care of handicapped children, mental hygiene in childhood, care of children's teeth, and prevention of accidents, observed at first hand in the various countries, are among the subjects reported on by the author, A. R. Smallwood, M. D., Director-General of Public Health, South Australia. Regarding advances in community health, Dr. Smallwood says, "Health training of children remains the most hopeful venture."

A blind boy learns

How a 3-year-old blind boy, whose widowed mother was employed, slowly learned to get along in a day nursery with 11 sighted children is told by the nursery-mother in the *Kansas Preschool Association Bulletin*, Winter 1955. ("Corky Comes to the Nursery," by Mrs. Royal Mayhan.) By the end of 5 months Corky had given up throwing tantrums, and had improved in many other ways, though he was still retarded in speech.

To express a truth

Psychiatry, above all other branches of medicine, requires a skill in communication, says the *Bulletin of the Menninger Clinic* for September 1955 in an article written by the late Harry Colburn, who before his death was responsible for giving training in writing to resident physicians at the Menninger School of Psychiatry. Noting that great truths, if poorly expressed, often fail to carry the conviction to which they are entitled, the article describes the efforts made at the School "to enable future psychiatrists to write competently for medical journals and clearly for local newspapers and for the private practitioner."

Ocular motor defects

Motor eye defects, extremely common in cerebral-palsied infants, are often unrecognized for 1 to 3 years, says George P. Guibor, M. D., in the *Journal of Pediatrics* for September 1955. Early treatment of these defects, the author notes, is often needed to prevent loss of vision in a deviating eye or to improve general motor ability, especially in patients with the types of cerebral palsy called athetosis and ataxia. The author suggests simple tests to enable physicians to discover an ocular motor defect or subnormal vision in a child, so that children with such defects can be referred to an eye doctor interested in children's eye diseases and their associated motor anomalies.

Petroleum poisoning

One of the commonest types of poisoning among young children is caused by petroleum products, chiefly kerosene, writes Hugh A. Carithers, M. D., in the *Journal of the American Medical Association*, September 10, 1955. In the United States one-fourth of all deaths of children under 5 from accidental poisoning are due to this cause, and large numbers of children become very ill from it. Noting that most kerosene poisonings take place in the South, the author states that in 1953 over 500 Florida children under 6 were treated, 229 of them as inpatients, for this type of poisoning. At least 5 died.

READERS' EXCHANGE

RIDENOUR: *"In there pitching"*

Dr. Ridenour and I have been fighting the battle of mental-health education for a good many years and I am glad to find her still in there pitching. (See "The Critics and Parent Education," by Nina Ridenour, CHILDREN, September–October 1955.) She brings vast experience, great knowledge, and deep integrity to this field.

I agree with Dr. Ridenour that there are all too many destructive, negative critics whose hostility is quite transparent but who, I believe, do no great harm. Headline seekers and feature writers are almost expected to distort; after all, they must make news and nothing is less newsworthy than calmly considered discussions of educational matters.

I am often more concerned about the friends of mental health than with our critics, even the hostile ones. I am certain that Dr. Ridenour would agree with me in my antipathy to the too easy promises of some Utopia ahead, of the great amelioration of a whole array of human ills and concerns, all as a result of this magic, mental hygiene. One finds much too much of that sort of thing and, unfortunately, it is often perpetrated by those who should know better.

I share Dr. Ridenour's conviction that evaluation is very difficult and that we still lack adequate criteria and techniques for undertaking it. I do not believe we can wait forever to establish ultimate truths. But I have always felt, and still do, that the field of parent education, as do other parts of the larger area of mental-health education, clings stubbornly to unproven and unprovable (and often wishful) shibboleths; and that we who work in this field are still loath to undertake the hard and often unrewarding task of scrutiny and self-examination.

I am not yet persuaded that either the opinions of authorities or the criterion of popularity, alone or combined, provide a method of evaluation on which one can rely. This is no quest for "scientific" proof, and my objection is not at all that these criteria are "unscientific." I simply believe that the facts demonstrating their validity are as yet not forthcoming, and that we need ever greater efforts at careful evaluation of the efficiency of what we are teaching. In this I am obviously in entire agreement with Dr. Ridenour's plea that "The important job is to assess . . .".

Sol W. Ginsburg, M. D.
New York

WOLINS: *Experiments in methodology*

I have read with interest Martin Wolins' letter commenting on the research contributions of Community Research Associates. ("Robinson: Data-sharing needed," in "Readers' Exchange," CHILDREN, September–October 1955.)

I am sorry Mr. Wolins does not approve of our publication policy. "Community Planning for Human Services" was designed for a general audience, few of whom have special interest in statistical techniques. It is a comprehensive treatise, which includes materials from many sources besides the St. Paul study.

Reports of the three subsequent studies were directed to the communities in which our projects were to be conducted. Each contains an explanation of the statistical approach and basic tables with data derived therefrom. These reports are available to any one interested, and we have reprinted two of them. Miss Robinson's article was based on their materials.

Essentially these projects are experiments in administrative and operational methodology. Procedures are changing continually in the light of experience. We feel it is a disservice to distribute generally descriptions of working processes before tests of practicality and utility have been completed. The Family Classification Project also is at a midway point; our present expectation is that findings from it will be published in book form.

Bradley Buell
Community Research Associates,
New York

RICHMOND: *Example from California*

In his article, "Medical Education in Transition," Dr. Julius Richmond has presented an excellent review of some of recent changes in medical education. (CHILDREN, September–October 1955.)

It should, however, be emphasized that there is considerable debate as to the value of some of these changes. The medical students' curriculum is now so full that for every new subject matter introduced something has to be eliminated from the curriculum. What scientific information can you safely eliminate?

For many years medical educators adhered to the concept that the medical-school graduate could learn all he needed to know about the sociological, cultural, and psychological aspects of patient care as he practiced. I believe that by and large this concept was valid in a limited way as long as our society was more rural and less mobile than it is today. When one doctor stayed in one community with the same patients for 20 to 30 years he learned a great deal about these people and this community that aided him in the comprehensive care of his patients. Such situations are much less common in our modern society. It is in recognition of major changes in society and in the practice of medicine with its trend toward specialization that many medical schools have introduced special courses integrating the sociological, cultural, and psychological aspects of patient care with the physical care.

At our school we feel that it has been very advantageous for our family medicine program to start the first year the student is in medical school. At this time the average medical student is greatly interested in the patient as a person, partly because he knows so little about organic disease. We believe we can encourage and develop this interest during the first 2 years of medical school to the point that the student continues in this direction on his own during his clinical years and in his hospital training period. Although we do work with the students during their last 2 years of medical training in their 4-year followup of their family medicine cases, we concentrate our efforts largely on the first 2 years. We also feel that limited clinical experience at this time stimulates the student's interest in his basic-science subjects and in medicine in general rather than detracts from his accumulation of scientific knowledge.

Arthur H. Parmelee, Jr., M. D.
Assistant Professor of Pediatrics, School of Medicine, University of California, Los Angeles

A crowded curriculum

Dr. Richmond's article on medical education is an excellent résumé of various aspects of the situation.

In my opinion, there is a trend toward crowding the curriculum at the expense of scientific experience and of time for reflection; toward didactic, required courses at the expense of elective work in the laboratory. One simply cannot cover systematically every aspect of medicine; indeed it is not desirable so to do.

The great advances in medicine have been attributable in large measure to scientific discoveries; the various psychological and social aspects of medical practice, often not expressed in modern terminology, have been empirically practiced for generations by the great clinicians. The compassionate physician is born rather than taught.

Dr. Richmond says "undergraduate medical education is not terminal education of the physician." Is it not for the great majority of doctors so far as vital experience with the exact sciences of the laboratory are concerned?

I believe experience in a research project at the undergraduate level is of potentially greater pedogogical importance at that stage than learning how to deal expertly with patients and families; and how to appraise accurately and sympathetically community and personal situations. One reason research is so important is that only in the formal setting of medical education is opportunity for exact and supervised observation and study of a special problem available to most students. In contrast, experiences with various social and psychological processes are bound to come sooner or later to every physician. I do not intend to emphasize relative importance but rather, sequence, availability, and opportunity.

In his article Dr. Richmond includes an important paragraph on the role of example in effective teaching of comprehensive care for patients. It is true, as he points out, that the medical-school framework for such teaching is somewhat idealized because facilities available to medical schools are not always available in other communities. But what is done in one community is stimulating to performance and accomplishment in those less favored. And, of course, one cannot exemplify in teaching less than the best known to the teacher.

I note the absence of the subject of medical history. Teaching of this important aspect of comprehensive medical care must not be neglected; formal courses are desirable but not necessary, if relevant material is adequately integrated in presentation.

Grover F. Powers, M. D.
Professor Emeritus of Pediatrics
Yale University

WITMER: *Anomie and child rearing*

In her presentation of the analysis of Baltimore data undertaken by Bernard Lander, Helen Witmer has clearly described the phenomenon of *anomie* as a possible major source of juvenile delinquency. ("Juvenile Delinquency and *Anomie*," CHILDREN, September–October 1955.)

The idea that "normlessness" in the life's sphere of a youngster is likely to lead him into juvenile delinquency has captured the attention of sociologists for some time. The full values of the concept and of its statistical analysis, however, are by no means established. Dr. Witmer's suggestions for further research on this and for its application to practice merit attention.

The question of whether *anomie* is not also to be found in the more prosperous segments of the population represents a significant research challenge. In recent years the writer has been impressed by a number of signs which suggest that there is in the making a philosophy of child rearing and education which represents dangerous errors in the interpretation of the Freudian discoveries. Apparently, our recognition of the power of an overstrict conscience has led many persons to the assumption that the superego creating forces are suspect by definition and that *they* should be restrained rather than impulses. Research into the relationship between *anomie and* juvenile delinquency may well explore the consequences of this widespread error upon the behavior of parents and teachers and thus of children and youngsters.

Otto Pollak
Department of Sociology, Wharton School of Finance and Commerce, University of Pennsylvania

A word of caution

In her commendable intent to maintain a simple and lucid style of exposition, Dr. Witmer found it necessary to omit reference to the definite, although not extensive, sociological literature on the ecology of juvenile delinquency. It should be noted, therefore, that Lander's study in both its methods and findings is strikingly similar to the two Shaw and McKay Chicago studies of 25 and 12 years ago respectively. The latter in particular, "Juvenile Delinquency and Urban Areas," found also that it is not the externals of the social environment such as housing, income, and the like, but the organization and spirit of social life which represents the relevant correlate of delinquency.

For this reason special emphasis should be given Dr. Witmer's word of caution regarding the dependability even of such sensitive indexes (for Baltimore) of the social life of a community as its racial heterogeneity and proportion of owner-occupied dwellings. In other cities, as for example Chicago, middle-class apartment house districts with low proportions of owner occupancy have low rates of delinquents. Similarly, many of Chicago's racially homogeneous areas have very high rates of delinquents, while on the other hand some of its racially heterogeneous areas have low rates. Hence, regardless of the sensitivity with which particular indexes may reflect the character of a community's social life at particular times and places they can be no more than *post facto* reflections of that social life, never causes.

The reduction of *anomie*, or social disorganization, found in areas of high rates of delinquents should, as Dr. Witmer proposes, remain the object of effort in delinquency-prevention programs, rather than merely the amelioration of its variable symptoms.

Solomon Kobrin
Sociologist, Chicago Area Project and Illinois Institute for Juvenile Research

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

EDUCATION FOR THE PROFESSIONS. Organized and edited by Lloyd E. Blauch. Department of Health, Education, and Welfare, Office of Education. 1955. 317 pp. Paper, $1.75; buckram, $2.75.

More than 30 professions are described in this report, a number of which directly concern children, including medicine, nursing, dentistry, public health, social work, physical and occupational therapy, home economics, and teaching. The publication reports the development, current problems, and educational status of each and lists schools offering professional study.

COUNSELING AND EMPLOYMENT SERVICE FOR YOUTH. Department of Labor, Bureau of Employment Security. 1954. 70 pp. 30 cents.

Among the subjects covered in this supplement to a more inclusive general handbook, "Counseling and Employment Service for Special Worker Groups," are: placement of beginners in suitable jobs; legal safeguards and labor standards for youth employment; school-employment service relationships; and employment counseling and placement of high-school graduates and drop-outs. An appendix reproduces forms used by various States in their programs for youth leaving school to enter employment.

PREMARITAL HEALTH EXAMINATION LEGISLATION; analysis and compilation of State laws. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 385. 1954. 114 pp. 40 cents.

This publication presents a history and compilation of the laws in the 40 States and 2 Territories that require blood tests and physical examinations for venereal disease.

DIRECTORY OF FULL-TIME LOCAL HEALTH UNITS, 1954. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. 118. Revised 1954. 58 pp. 25 cents.

Revised July 1954, this directory lists, by State, full-time health units serving local areas, together with the name of the health officer of each unit, or other designated administrative head.

JOB GUIDE FOR YOUNG WORKERS; 1955 supplement. Department of Labor, Bureau of Employment Security. 10 pp. 10 cents.

This supplement to a bulletin noted in the November–December 1954 issue of CHILDREN offers job-guide information on five types of clerical-and-sales jobs and two in the mechanics-and-repairmen group.

PUBLIC TRAINING SCHOOLS FOR DELINQUENT CHILDREN; directory, May 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 70 pp. 25 cents.

This directory of training schools, the fourth published by the Children's Bureau, includes information on the 172 training schools under public auspices in the 48 States, the District of Columbia, Hawaii, Puerto Rico, and the Virgin Islands.

PLANNING TYPE A SCHOOL LUNCHES. Department of Agricultural Marketing Service. PA No. 264. 1955. 10 pp. 10 cents.

To help local school-lunch workers plan nutritious and appetizing noonday meals at a price the children can afford, this guide relates the dietary needs of children to the requirements of the basic lunch pattern known as Type A, explains the steps in menu planning, provides sample menus that meet the pattern's requirements, and includes a check list for evaluating menus.

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